# Lily Lee, MD

Plastic & Reconstructive Surgery

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www.LilyLeemd.com

100 E. California Blvd
Pasadena, Ca 91105

73180 El Paseo
Palm Desert, Ca 92260

Date: _____

Name: _____ Age: _____ DOB: _____/_____/_____

Address: _____ Cell: (_____)_____

City _____Zip_____ Alt. Tel: (_____)_____

Email: _____ FB._____ Instagram: _____Snap Chat: _____

Referring Physician: _____ SS# _____

**Preferred Pharmacy/ Address:**_____ **Pharmacy Phone Number:**_____

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How did you hear about Dr. Lee? _____

Have you been to our website (www.lilyleemd.com)?_____ Was our website helpful? □No □Yes If No, pls. list reason:

_____

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What is the reason for your visit today? (Circle all applicable procedures below)

| Nose & Face | Breast & Body | MediSpa |
|---|---|---|
| Brow Lift | Breast Augmentation | Botox® |
| Droopy Eyelids | Breast Lift | Fillers |
| Eye bags/Puffiness | Breast Reduction | Ultherapy |
| Eyelid Surgery | Breast Implant Revision | Thinning Hair/Eyelashes |
| Face Lift | Mommy Makeover | Pore Tightening |
| Neck Lift | Abdominoplasty (Tummy Tuck) | Scar Treatment |
| Lasik | Coolsculpting | Wrinkle Anti-aging Treatments |
| Chin Augmentation | Brachioplasty (Arm Tuck) | Micro-Needling |
| Ear Tuck | Liposuction | Photo Facial |
| Rhinoplasty | Fat Grafting | Microdermabrasion |
| | Other_____ | Vein Treatment |
| Other_____ | Other_____ | Kybella |
| | | PDO thread lift |
| Other_____ | Other_____ | Other_____ |

Please describe why you are interested in having the procedure(s) listed above:_____

_____

_____

Have you consulted with other physicians about procedure(s) indicated above: □No □Yes

If Yes, please describe your understanding of the procedure(s)_____

Is this procedure a revision from a previous surgery □No □Yes If yes, how many previous surgeries?_____

What is your "ideal time frame" for procedure(s) completion _____

Do you have reliable transportation? _____ Who will be transporting you to and from the surgery center? _____

| Age _____ | Weight _____ | Height _____ | B/P _____ (taken in office) |
|---|---|---|---|

Employer _____ Address _____

Occupation: _____ Marital Status: _____

**Primary Insurance Co**. _____ Policy # _____

Group # _____ Name of person insured _____ SS# _____

Eligibility Phone # _____ Copay _____

**Secondary Insurance Co**. _____ Policy # _____

Group # _____ Name of person insured _____ SS# _____

Eligibility Phone # _____ Copay _____

## HEALTH INFORMATON

Personal Past History:

Do you have any chronic medical problems? (Circle all that apply)

| | | |
|---|---|---|
| High Blood Pressure | Diabetes | Cancer |
| Heart Disease | Kidney Disease | HIV or AIDS |
| Heart Failure | Psychiatric Diagnosis | Stroke |
| Seizures | Bleeding Problems | Hepatitis |
| Heart Attack | Liver Disease | Emphysema |
| Chest Pain | Gastric Reflux | Stomach Problems |
| | Asthma | Other _____ |

Is there a personal or family history of anesthetic complications? □No □Yes

If yes, please explain_____

Do you have a history of falls? □No □Yes

If yes, have you discussed with your primary care doctor? □No □Yes

Have you had your flu vaccine this year? □No □Yes

Family History:

Do you have a family history of any medical problems? (Circle all that apply) Please indicate family member.

| | | |
|---|---|---|
| High Blood Pressure | Diabetes | Cancer |
| Heart Disease | Kidney Disease | HIV or AIDS |
| Heart Failure | Psychiatric Diagnosis | Stroke |
| Seizures | Bleeding Problems | Hepatitis |

| | | |
|---|---|---|
| Heart Attack | Liver Disease | Emphysema |
| Chest Pain | Gastric Reflux | Stomach Problems |
| | Asthma | Other _____ |

| Please list all prior operations: | Date | List any complications |
|---|---|---|
| 1._____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |

| Please list all prior Hospitalizations: | Date | List any complications |
|---|---|---|
| 1._____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |

Please list **ALL** medications and/or dietary supplements including:
**(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)**

| | |
|---|---|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Please list **ALL** allergies and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc).

| | |
|---|---|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |

Social History:
Have you ever used tobacco products? □No □Yes If yes, how long?_____ how much?_____
Which tobacco product(s) have you used?_____

If you are a former smoker, state the year you stopped: _____
Past or current use of Nicotine Gum, Patch, or any other type of stop-smoking aid: □No □Yes
If yes, please list: _____

Alcohol Consumption: _____Never (Do not consume alcohol) _____ Rare (1-2 drinks a week)

_____ Moderate (7-10 drinks a week) _____ Heavy (daily or more than 10 drinks a wk)

Did you ever drink heavily in the past? □No □Yes
Are you feeling hopeless about the present/future? □No □Yes
Do you currently have thoughts of harming yourself? □No □Yes

Review of Systems:
Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR

| | | | |
|---|---|---|---|
| High Blood Pressure | Y ___ N ____ | Heart Failure | Y ___ N ____ |
| Heart Attack | Y ___ N ____ | Irregular Heartbeat | Y ___ N ____ |
| Angina/chest pain | Y ___ N ____ | Heart Murmur | Y ___ N ____ |
| Heart bypass surgery | Y ___ N ____ | Do you exercise? | Y ___ N ____ |
| Pacemaker | Y ___ N ____ | Comments: _____ | |

NEUROLOGICAL

| | |
|---|---|
| Stroke | Y ___ N ____ |
| Seizures | Y ___ N ____ |
| Fainting | Y ___ N ____ |
| Dizziness | Y ___ N ____ |
| Headache | Y ___ N ____ |
| Double Vision | Y ___ N ____ |

PSYCHIATRIC

| | |
|---|---|
| Depression | Y ___ N ____ |
| Anxiety | Y ___ N ____ |
| Psychiatric Care | Y ___ N ____ |
| Obsessive Compulsive Disorder | Y ___ N ____ |

ENDOCRINE

| | |
|---|---|
| Diabetes | Y ___ N ____ |
| Thyroid Disease | Y ___ N ____ |
| Taken Steroids | Y ___ N ____ |

HEMATOLOGIC/ONCOLOGIC/

| | |
|---|---|
| Bleeding Tendency | Y ___ N ____ |
| Easy Bruising | Y ___ N ____ |
| Anemia | Y ___ N ____ |
| Sickle Cell Disease | Y ___ N ____ |
| Blood clots in legs | Y ___ N ____ |
| Blood clots in lungs | Y ___ N ____ |
| Radiation Therapy | Y ___ N ____ |

URINARY/REPRODUCTIVE

| | |
|---|---|
| Kidney Disease | Y ___ N ____ |
| Urinary Disease | Y ___ N ____ |
| Dialysis | Y ___ N ____ |
| If Female, could you be preg? | Y ___ N ____ |
| Number of live births_____ | |

RESPIRATORY

| | |
|---|---|
| Abnormal Chest X-ray | Y ___ N ____ |
| Asthma | Y ___ N ____ |
| Bronchitis | Y ___ N ____ |
| Emphysema | Y ___ N ____ |
| Recent Chest Infection | Y ___ N ____ |
| Shortness of Breath | Y ___ N ____ |
| Shortness of Breath at night | Y ___ N ____ |
| Shortness of Breath on exertion | Y ___ N ____ |
| Cough | Y ___ N ____ |
| Cough with Sputum | Y ___ N ____ |
| Sleep Apnea | Y ___ N ____ |
| -Use a C-PAP Machine | Y ___ N ____ |

MUSCULOSKELETAL

| | |
|---|---|
| Sciatica | Y ___ N ____ |
| Herniated disc | Y ___ N ____ |
| Arthritis | Y ___ N ____ |
| Rheumatoid | Y ___ N ____ |
| Neck, Back, Arm,Leg Prob | Y ___ N ____ |

INFECTIOUS

GASTROINTESTINAL

| | |
|---|---|
| Jaundice | Y ___ N ____ |
| Hepatitis | Y ___ N ____ |
| Ulcers | Y ___ N ____ |
| Hiatal Hernia | Y ___ N ____ |
| Heartburn | Y ___ N ____ |

SKIN

| | |
|---|---|
| Basal cell skin cancer | Y ___ N ____ |
| Melanoma | Y ___ N ____ |
| Staph Infection | Y ___ N ____ |

EYES

| | |
|---|---|
| Cataracts | Y ___ N ____ |

Number of pregnancies _____ Glaucoma Y ___ N ____
Date of last mammogram _____
Date of date of menses (period)_____

**ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance coverage with _____ and assign directly to Lily Lee, M.D., Professional Corporation, all Medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. If the nature of the disability be such that it is not covered by insurance, I will be responsible to the doctor for payment of the entire bill. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

_____ _____
Patient's Signature Date