New Patient Information

What procedures would you like to receive more information on?			
☐ Facial Aging	☐ Nose	☐ Fraxel™ or LASER Resurfacing	☐ Chemical Peel
☐ Ears	☐ Chin / Jaw Line	☐ Vein Treatment	☐ Thermage
☐ Neck	☐ Skin Concerns	☐ Brown Spot Treatment	☐ Restyline/ Filler
☐ Eyelids	☐ Brow / Forehead		☐ Botox/Dysport
☐ Wrinkles / Lines	☐ Lips		☐ Skin Care
☐ Facial Scar	☐ Other: _____		☐ Other: _____

Tell us about you.			
Patient Name:			
Address:			
City:	State:	Zip:	
Date of Birth:	Sex:	Marital Status:	☐ Single
Home Phone:			☐ Married / Partnered
Cell Phone:			☐ Divorced
Work Phone:			☐ Widowed
E-Mail Address:		Drivers License #	
Would you like to receive our e-newsletter: ☐ Yes ☐ No			
Occupation:			
Emergency Contact:	Emergency Contact Phone:		
Emergency Contact Address:			
City:	State:	Zip:	

Your healthcare provider information			
Primary Care Physician		Ophthalmologist	
Dermatologist		Other Physician	

How did you hear about Portland Laser & Surgery Center?			
☐ Word of Mouth ☐ Website ☐ Facebook	☐ Website ☐ Google Search ☐ Yahoo Search	☐ Winged M ☐ Oregonian ☐ Radio	☐ Event ☐ Other
Is there a patient we can reward for referring you?			

What is the best way to contact you after your consultation?			
☐ E-Mail	☐ Mail	☐ Phone	☐ Do Not Contact
☐ **Please check here if you do NOT want correspondence mailed to your home address.**			
Signature		**Date**	

PORTLAND FACE DOCTOR
David D. Magilke, MD, PC
Board Certified Facial Plastic Surgeon

Updated: 06.11.2013
Effective Date: 04.16.2013

Patient Health History

Your Current Information

Name:

Age: Height: Weight:

Are you pregnant?	☐ Yes	☐ No	
Are you nursing	☐ Yes	☐ No	
Taking Birth Control	☐ Yes	☐ No	
Do you smoke?	☐ Yes	☐ No	Packs Per Day? How long?
Do you drink?	☐ Yes	☐ No	Amount Per Week?

Do you have now or have you ever experienced any of the following?

High Blood Pressure	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Asthma / Lung Disease	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No	Stomach Problems	☐ Yes	☐ No
HIV / AIDS	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	Psychiatric Disease	☐ Yes	☐ No
Accutane	☐ Yes	☐ No	Herpes	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Laser Resurfacing	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Material Allergies - Latex, etc	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Autoimmune Disorder	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Pacemaker / Heart Surgery	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Chemical Peel	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Scarring, Keloid	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Cortisone Treatment	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Cough - Persistent	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Fainting	☐ Yes	☐ No	Surgical Implant	☐ Yes	☐ No
Food Allergies	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Tobacco	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Ulcer or Reflux	☐ Yes	☐ No

Do any of your blood relatives have a history of any of the following? ☐ Family History Unknown

High Blood Pressure	☐ Yes	☐ No	Neurological Disease	☐ Yes	☐ No
Asthma / Lung Disease	☐ Yes	☐ No	Hearing Loss	☐ Yes	☐ No
Stomach Problems	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Bleeding Disorder	☐ Yes	☐ No
Immune Disease	☐ Yes	☐ No	Psychiatric Illness	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Type of Cancer?		

Are you allergic to any medications? ☐ NA

☐ Aspirin	☐ Demerol	☐ Erythromycin	☐ Local Anesthetic
☐ Codeine	☐ Penicillin	☐ Sulfa	☐ Iodine
☐ Morphine	☐ Tetracycline	☐ Keflex, Ceclor, Ceftin	Other

PORTLAND FACE DOCTOR
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Patient Health History, Continued

Have you ever had Botox or Dysport treatment?	☐ Yes	☐ No	If yes, what area?
Have you ever had a Juvederm treatment?	☐ Yes	☐ No	If yes, what area?
Have you ever had a Radiesse treatment?	☐ Yes	☐ No	If yes, what area?
Are you using Retin A?	☐ Yes	☐ No	If yes, what strength / how long?
Have you ever had a chemical peel?	☐ Yes	☐ No	If yes, what type / when?
Are you now or have you ever taken medication for cold sores or herpes simplex?	☐ Yes	☐ No	If yes, what type / when?
Do you sun in a tanning bed?	☐ Yes	☐ No	If yes, when did you tan last?

Please list any current medications you are taking, including doses. ☐ NA

Please list any surgeries you have had, including cosmetic. ☐ NA

Please list any non-surgical conditions you have been hospitalized for. ☐ NA

Skin Evaluation and Product Information (Check all that apply)

- ☐ Sun damage
- ☐ Brown spots or splotchy uneven skin color
- ☐ Wrinkles – Deep
- ☐ Wrinkles – Fine
- ☐ Upper lip lines
- ☐ Clogged pores
- ☐ Normal to dry skin
- ☐ Normal to oily skin
- ☐ Excessive oiliness
- ☐ Acne
- ☐ Pimples
- ☐ Blackheads
- ☐ Whiteheads
- ☐ Visible exposed blood vessels

Products currently being used (Check all that apply)

- ☐ Cleanser
- ☐ Moisturizer
- ☐ Eye Cream
- ☐ Scrub
- ☐ Soap
- ☐ Night Cream
- ☐ Astringent
- ☐ Sunscreen
- ☐ Toner
- ☐ Vitamin C Serum
- ☐ Mask
- ☐ Other:

OFFICE NOTES

PORTLAND FACE DOCTOR
David D. Magilke, MD, PC
Board Certified Facial Plastic Surgeon

Updated: 06.11.2013
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Skin Typing

Name: **Date:**

Please answer the questions by checking the answer that best describes you.
(Your clinician will total the score during your consultation)

My ethnic origin is closest to:	I.	Very fair	☐ -
	II.	Fair-skinned – light hair and eyes	☐ -
	III.	Pale-skinned – dark hair and eyes	☐ -
	IV.	Olive-skinned	☐ -
	V.	Dark-skinned	☐ -
	VI.	Very dark-skinned	☐ -
My eye color is:		Light Blue	☐ - 0
		Blue / Green	☐ - 1
		Green / Gray / Golden	☐ - 2
		Hazel / Light brown	☐ - 3
		Brown	☐ - 4
My natural hair color at age 18 was:		Red	☐ - 0
		Blonde	☐ - 1
		Light brown	☐ - 2
		Dark brown	☐ - 3
		Black	☐ - 4
The color of my skin that is not normally exposed to sun is:		Pink to reddish	☐ - 0
		Very pale	☐ - 1
		Pale with a beige tint	☐ - 2
		Light brown	☐ - 3
		Medium to dark brown	☐ - 4
		Dark brown-black	☐ - 6
If I'm in the sun for an hour or so without sunscreen and have not been in the sun for weeks, my skin will:		Burn, blister and peel	☐ - 0
		Burn – No color change after burn resolves	☐ - 1
		Burn – Turns tan after a few days	☐ - 2
		Pink – Turns tan quickly	☐ - 3
		Tan	☐ - 4
		Gets darker	☐ - 5
		Skin color is too dark to tell	☐ - 6
		TOTAL SCORE	

If your score is:	Your skin type is:	Notes
0 – 3	I	
4 – 7	II	
8 – 11	III	
12 – 15	IV	
16 – 19	V	
20 – 24	VI	

Notice of Patient Privacy

I authorize Dr. David Magilke to use and disclose my health and medical information for the purpose of treatment, payment and healthcare procedures.

Treatment: Includes any procedures performed by a physician, nurse, office staff and/or any other type of healthcare professional that coordinate or manage your healthcare needs. This consent form also includes any treatment provided by a physician who covers Dr. David Magilke's practice by telephone as the on-call physician.

Payment: Includes any financial activities that involve determining your eligibility for health plan coverage, billing and receiving payments for your health benefit claims and permission to review any healthcare service for medical necessity, justification of charges, collections, or pre-certification and/or preauthorization.

Health Care Procedures: Includes the necessary administrative and business function of Dr. David Magilke.

You may review our "Notice of Privacy Practices" for additional information about the uses and disclosure of information described in this consent form; prior to signing this consent form, please verify that you have received a copy of our Notice by placing your initials here:_____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be available at the front desk of our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first office visit. We will also provide you with a copy of the Notice upon request.

As explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment and healthcare procedure purposes. However, we are not required to agree to your request. If we do agree, we are required to comply with your request unless information is needed for emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice. I understand that I have the right to revoke this consent form provided that I do so in writing, except to the extent that Dr. David Magilke has already used or disclosed the information in confidence on this consent form.

Patient Signature **Date**