THE LANGSDON CLINIC

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Consultation and Medical Questionnaire

Name ______________________ Date of Birth __________ Today's Date __________
Home Address: Street ______________________ City ______________________
State __________ Zip __________ Home Phone __________
Work ______________________
Cell __________ Email ______________________
Marital Status: ❒ S ❒ M ❒ D ❒ Sep Occupation __________ Ages of Children __________
Emergency Contact: ______________________ Relationship __________
Work Phone __________ Home Phone __________
How were you referred to us? ______________________
Names of family members who are our patients ______________________
In which procedure(s) are you interested? (please check each applicable block)

❒ Rhinoplasty (nose) ❒ Chin ❒ Face or neck lift ❒ Eyelids
❒ Chemical peel/Dermabrasion ❒ Scar revision ❒ Protruding ears ❒ Non-surgical Fillers
❒ Hair Transplant ❒ Day Lift ❒ Laser procedures ❒ Other

What specifically do you wish to have corrected? (i.e. what don't you like about the above condition(s)?)
____
Do you desire improvement in both appearance and function? ❒ Yes ❒ No
When did you begin to consider surgical correction? ______________________
Why have you decided to have it done at this point in time? ______________________
Have you consulted any other doctor about this? (when?) ______________________
Have you discussed this surgery with your family? ❒ Yes ❒ No
Have you had any other surgery, or an injury, to the face, nose, neck or eyes? ❒ Yes ❒ No
When? __________ Describe, what was done ______________________
Who performed the surgery? __________ Where was it performed? __________
Were you satisfied with the results? ❒ Yes ❒ No If not, why? __________
Has anyone in your family or a close friend had cosmetic or reconstructive surgery? ❒ Yes ❒ No
What was done? __________ By whom? __________
Have you had any other surgery? ❒ Yes ❒ No What was done and when was it performed?

❒ In the head and neck area? __________ ❒ On your skin? __________
❒ On your teeth or gums? __________ ❒ In your chest? __________
❒ In your abdomen? __________ ❒ On the reproductive system? __________
❒ On your back, arms or legs? __________ ❒ Other __________

Were there any complications? Did you have a normal recovery? ❒ Yes ❒ No
Were you satisfied with the results? ❒ Yes ❒ No If not, why? __________

MEDICAL HISTORY (check the appropriate responses)

❒ Yes ❒ No Are you now taking any drugs, medications, diet aids, or vitamins? How often? __________
List them, please ______________________
❒ Yes ❒ No Are you allergic to any medications? ______________________
List them, please ______________________
❒ Yes ❒ No Are you allergic to latex? Describe ______________________
When was your last physical examination? __________ Who is your family doctor? __________
Doctor's address __________ Phone number __________
❒ Yes ❒ No Would you object to our contacting him/her in regard to any medical problem that might arise?
❒ Yes ❒ No Have you ever received local anesthesia ("Novocaine or Xylocaine") by a dentist or physician?
❒ Yes ❒ No Did you have any "reaction" to any anesthetic? Explain

(continued on back)

MEDICAL HISTORY (continued)

❒ Yes ❒ No Are you considered a healthy person?

Do you or any family member have: (check applicable block(s) and note family member)

❒ Heart trouble ______________________ ❒ Excessive bleeding tendencies ____________
❒ Psychiatric or "nerve" problems __________ ❒ High blood pressure ____________________
❒ Diabetes ___________________________ ❒ Thyroid problems ______________________
❒ Excessive bruisability ________________ ❒ Excessive scarring _____________________

Do you have a history of bleeding: (indicate which)

❒ From the nose ❒ In the urine ❒ Vomiting blood ❒ From the rectum
❒ Coughing up blood ❒ Other ____

❒ Yes ❒ No Do you have hay fever, nasal allergies or asthma? Explain? ______________________
❒ Yes ❒ No Do you have or have you had any problems with your eyes or vision? Explain ____________
❒ Yes ❒ No Do you have frequent pains in your chest? Explain ____________________________
❒ Yes ❒ No Has your doctor ever said you had "heart trouble"? Explain ______________________
❒ Yes ❒ No Do you have "stomach trouble" or ulcers? Explain ____________________________
❒ Yes ❒ No Do you have or have you had chest or lung problems? Explain ____________________
❒ Yes ❒ No Have you ever had liver, gall bladder trouble or "yellow jaundice"? (Circle which one.)
❒ Yes ❒ No Have you been bothered by kidney or bladder problems? Explain __________________
❒ Yes ❒ No Do you or any family members suffer from "arthritis"? Explain ____________________
❒ Yes ❒ No Do you have frequent skin infections, irritations, or rashes? (Circle which one.)
❒ Yes ❒ No Do you often have severe headaches or dizzy spells? (Circle which one.)
❒ Yes ❒ No Has any part of your body ever been paralyzed or numb? Explain __________________
❒ Yes ❒ No Have you ever had a convulsion or seizure? Explain ____________________________
❒ Yes ❒ No Have you ever received treatment for your genital area? Explain __________________
❒ Yes ❒ No Have you ever been treated for any venereal disease? Explain ____________________
❒ Yes ❒ No Are your frequently sick or ill?
❒ Yes ❒ No Do you worry about your health?
❒ Yes ❒ No Were you ever treated for anemia or any problems with your blood? Explain ____________
❒ Yes ❒ No Have you ever taken hormones or thyroid medication? Explain ____________________
❒ Yes ❒ No Do you smoke? How many cigarettes per day? _____
❒ Yes ❒ No Do you drink more than 6 cups of coffee a day?
❒ Yes ❒ No Do you usually take two or more alcoholic drinks a day?
❒ Yes ❒ No Have you ever received treatment for abuse of alcohol or drugs? Explain ______________
❒ Yes ❒ No Do you often get depressed?
❒ Yes ❒ No Do you usually feel unhappy or depressed?
❒ Yes ❒ No Are you considered a nervous person?
❒ Yes ❒ No Have you ever had a "nervous breakdown"? Explain ____________________________
❒ Yes ❒ No Are you easily upset or irritated?
❒ Yes ❒ No Do you tend to hold a "grudge" when someone angers you?
❒ Yes ❒ No Have you ever considered consulting a psychiatrist or psychologist? Explain ____________
❒ Yes ❒ No Have you ever been under the care of a psychiatrist or psychologist? Explain ____________

WOMEN ONLY: When was your last menstrual period? ______________________________
❒ Yes ❒ No Are your periods often irregular?
❒ Yes ❒ No Have you had "female" or GYN problems? Explain ________________

MEN ONLY: ❒ Yes ❒ No Have you ever had prostate problems? Explain ____________________

MEN AND WOMEN:

❒ Yes ❒ No Do you accept the fact that every medical and surgical treatment is associated with risks and other imponderables?
❒ Yes ❒ No Do you have any other medical problems that have not been covered? Explain ___________

Signed ____ Date ____________________

Notice of Privacy Practices

PLEASE KEEP THIS FOR YOUR RECORDS.

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for medical information, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: we will use and disclose your health information to provide you with medical treatment or services. For example nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We may use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and service that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

- Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- Public Health Activities: As required by law, we may disclose vital statistics diseases, information related to recalls of dangerous products, and similar information to public health authorities.
- Health Oversight: We may be required to disclose information to assist in investigations and audits eligibility for government programs, and similar activities.
- Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order
- Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials
- Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies
- Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person
- Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
- Research: We may use or disclose information for approved medical research

- Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illnesses.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can revoke the authorization to stop any future uses and disclosures.

Individual Rights
You have the rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Change in Privacy Practices
We may change our policies at any time Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:
Priscilla Farrell
7499 Poplar Pike
Germantown, TN 38138
901-755-6465

Effective Date:
The effective date of this Notice is October 16, 2003.