P: 813-579-3369 & F: 866-202-3227
www.wayneleemd.com

Brandon Office
1020 E. Brandon Blvd, Suite 101
Brandon, FL 33511

Tampa Office
3000 Medical Park Dr. Ste 140
Tampa, FL 33613

Patient History

Date:_____

Patient Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Phones: (Home): _____ (Cell): _____

Email: _____ (If you would prefer not to receive email communication from WLMD and Real Self, please leave the email line blank.)

Social Security #: _____-_____-_____

Driver's License #: _____ State: _____Exp: _____

Age: _____ Birthdate: (mm/dd/yy): _____ /_____ /_____ Gender: M / F Ethnicity: _____(opt)

Height: _____ ft _____ in. Weight: _____ lbs

Occupation: _____ Employer: _____

Marital Status (please circle one): Single – Married – Widowed – Divorced – Separated

Spouse's Name: _____

Emergency Contact, Name: _____ Relation: _____ Ph: _____

Nearest relative not living with you: _____ Relation: _____

Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Confidential Health Information Release

Name (Print): _____ MI: _____

I authorize this medial office or its affiliates to leave confidential health information voicemail at the following phone number if I'm not available: _____Type of Ph: H / W/ Cell

I authorize this medical office or its affiliates to send confidential health information to the following address:

_____City: _____ State: _____ Zip: _____

Signature: _____ Date:_____

Reason for today's Visit: _____

Referring Physician: _____ Family Physician: _____

Other Physician:_____

Patient Name: _____

Pharmacy Information

Pharmacy name: _____ Location: _____

Phone number: _____ Fax number: _____

Social History

Smoking: (circle) YES, NO, QUIT: _____ Types: _____Cigarettes, ____ Cigars, _____ Chewing Tobacco

Packs per Day: _____ Years Smoked: _____

Alcohol: (circle) YES, NO, QUIT # of Drinks per Week: _____

Illegal Drugs: (circle) YES, NO, QUIT Type: _____ Frequency: _____ IV Drugs? Y/N

Check below all illnesses that you have/had:

____ Allergies	____ Asthma	____ Bleeding Tendencies	____ Diabetes	____ Epilepsy
____ Diverticulosis	____ Eczema	____ Depression/Anxiety	____ Emphysema	____ Glaucoma
____ Eye Disease	____ Reflux	____ Gastroesophageal	____ Glaucoma	____ Hernia

____ Heart Disease	____Gout	____ Heart Disease	____ Hemorrhoids	____ Thyroid
____ Kidney Disease	____ Neuritis	____ Liver Disease	____ Tuberculosis	____ Pancreatitis
____ Osteoarthritis	____ Stroke	____ Ulcers (Duodenal)	____ Irritable Bowel Syndrome	
____ Ulcers (leg)	____ Rheumatic Fever		____ Hepatitis, Type: _____	
____ Obstructive Sleep Apnea		____ High Blood Pressure	____ Cancer/Tumors. Type: _____	

Sexually Transmitted Disease, Type: _____

Do you have a pacemaker? ____ Yes, ____ No Are you HIV positive? ____ Yes, ____ No

List all other illnesses you've had: _____

_____

Surgeries

Type	Month/Year	Surgeon/Hospital

Pregnancies

Number of Pregnancies: _____

Number of Children:

Males _____ Ages: _____ Females _____ Ages: _____

_____

Patient Name: _____

Medications

Are you currently taking any medications: Yes ____ No ____ Please list all medications:

_____

_____

Are you currently taking any of the following blood thinners? Please circle.

Aspirin	Plavix	Warfarin (Coumadin)	Fish Oil		Fragmin
Coumadin	Dicumarol	Miradon	Clexane	Arixta	
Orgaran	Innohep	Argatroban	Reludan		Angiomax
Pradax	Plavix	Persantine Aggrenox			

Allergies

Pencillin (reaction):	Cephalosporin(e.g. Keflex)(reaction):
Sulfa (reaction):	Aspirin (reaction):
Codeine (reaction):	Morphine (reaction):
Latex (reaction):	Other (reaction):

Family Medical History

Have you or anyone in your family had problems with anesthesia? _____ Yes, _____ No

Check below if any of the following conditions have occurred on either side of the patient's family:

____ Allergies	____ Bone Disease	____ Diabetes
____ Breast Cancer	____ Kidney Disease	____ Tuberculosis
____ Melanoma Skin Cancer	____Thyroid Disease	____ Pulmonary Disease
____ Other Cancer	____ Congenital Deformities	____ Bleeding Tendencies
____ Gastrointestinal Disease	____ Heart Disease/Cardiovascular	____ Keloid Scars

Other (please list all):

_____

Review of Symptoms

Constitutional:	____ Weight Loss	____ Fatigue	____ Fever
Cardiovascular:	____ Chest Pain	____ Cyanosis	____ Shortness of Breath
	____ Ankle Edema	____ Frequent Urination at Night	
Respiratory:	____ Cough	____ Coughing Blood	____ Wheezing
	____Use of Oxygen	____ Shortness of Breath	
Musculoskeletal:	____ Pain	____ Tenderness	____Muscle Weakness
	____ Joint Swelling		
Endocrine:	____High Blood Sugar	____ Excessive Thirst	____ Intolerance of Heat or Cold
Hematology/Lymphatic:	____ Anemia	____ Bruise Easily	____ Enlarged Lymph Node
Allergy/Immunologic:	____ Itchy	____ Frequent Infection	____ Inhalant or Food Allergy
GU:	____ Burning	____ Urinary Infections	____ Urine in Blood
Eyes:	____ Blindness	____ Red Eyes	____ Double or Blurry Vision
Skin:	____ Rash	____ Lumps	____ Sores
	____ Loss of Hair		
Psych:	____ Anxiety	____ Sleep Disturbances	____ Nervousness
	____ Memory Loss		
GI:	____ Nausea	____ Vomiting	____ Diarrhea
	____ Vomiting Blood	____ Indigestion	____ Difficulty Swallowing
Neuro:	____ Paralysis	____ Head Injury	____ Head Aches
	____ Numbness	____ Blackouts	

How were you referred to our office? Please check all that apply.

____ Physician Referral & Physician Name: _____

____ Hospital Affiliation & Name: _____

____ Patient Referral & Name: _____

____ Word Of Mouth	____ Driving By	____ E-Mail	
____Website	____ Facebook	____ Tampa Bay Surgical Arts	
____ Bella Medspa	____ RealSelf	____ Yelp	
____ Citysearch	____Vitals	____ Healthgrades	
____ Merchant Circle	____ Insider Pages	____ Thumbtact	____ Return 2 Fitness

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my healthcare, Wayne Lee MD Plastic Surgery, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plan for future plan for treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided a Notice of Privacy Practices that provides more completed description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Wayne Lee MD Plastic Surgery PLLC is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance there on. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse treatment as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Wayne Lee MD Plastic Surgery PLLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Wayne Lee MD Plastic Surgery PLLC change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to use or disclosure of my health information:

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent.

Patient Name (Please Print):

_____

Patient Signature: Date

_____

WAYNE LEE MD
Plastic & Reconstructive Surgeon
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Authorization For & Release of Medical Photographs, Slides, and/or Videotapes

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides, and/or videotapes and to use these images for a purpose as defined within this consent document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

Medical photographs, slides, and videotapes may be taken before, during, or after surgical procedure of treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photographs, slides, and videotapes for a stated purpose.

Consent to Take Photographs, Slides, and/or Videotapes

I hereby authorize Wayne Lee MD Plastic Surgery and/or his associated or licensees to take pre-operative, intra-operative, or post-operative photographs, slides, and/or videotapes.

Consent for Release of Photographs, Slides, and/or Videotapes

I hereby authorize Wayne Lee MD Plastic Surgery and/or his associate or licenses to use pre-operative, intra-operative, or post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to show these images on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, advertising purposes, or during lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment of any other consideration as a result of any use of the images.

Patient Name (Please Print):

_____

Patient Signature: Date:

_____

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Medical Records Request/Release Form

Patient Name: _____

Patient DOB: _____SSN:_____

I hereby authorize Wayne Lee MD Plastic Surgery, PLLC *to Release/Request* my medical Records *to/from*:

NAME:_____

Location
Address:_____

_____

Phone: _____Fax:_____

Email: _____

Reason For Request: _____

Date needed: _____

Records Needed: (Please specify which medical records are needed for the above patient. For instance, Doctor's office visit notes, operative reports, prescriptions, lab work, diagnostic test results, x-rays, MRI Results, etc. Doing so will help with efficiency in processing the request. Thank you for your cooperation.)
_____

_____

_____

Patient's Signature_____Date:_____

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I would like to know more about the following…

Surgical Procedures

- ☐ Breast Augmentation
- ☐ Revision Augmentation
- ☐ Mastopexy (Breast Lift)
- ☐ Breast Reduction
- ☐ Gynecomastia
- ☐ Abdominoplasty
- ☐ Liposuction
- ☐ Rhinoplasty
- ☐ Eyelid/Brow lift
- ☐ Facelift
- ☐ Necklift
- ☐ Brazilian Buttlift
- ☐ Arm lift
- ☐ Thigh lift
- ☐ Cellulaze for Cellulite
- ☐ Smart lipo

Non Surgical Procedures

- ☐ Botox
- ☐ Juviderm
- ☐ Obagi
- ☐ Latisse
- ☐ Coolsculpting