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:______________________________________

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

Patient Name: ________________________

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: ____

Operations

Type Month/Year Surgeon/Hospital

Pregnancies

Number of Pregnancies: ________________
Number of Children:
Males ________________ Ages: ________________ Females ________________ Ages: ________________

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):

Patient Name: ___________________

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

Patient Name:___________________________

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

____

Patient Name:_______________________
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:

____