Vinings Surgery Center

PATIENT INTAKE FORM

Dear Patient,

Thank you for contacting us regarding our services at Vinings Surgery Center and for scheduling an appointment with us. You can feel confident that our staff is committed to meeting your needs. Dr. Colgrove is looking forward to meeting you. Please be assured that Dr. Colgrove and his staff will work with you to prepare the best plan for you while taking the time to address all of your specific needs.

At Vinings Surgery Center, we strive to provide the most current, safe and effective procedures available today. By combining procedures that have stood the test of time with newly proven advances in technology, our office is on the cutting edge and able to provide you with the best options available.

In order to minimize your wait time, please complete these New Patient forms prior to your visit and bring them with you to your appointment. In the meantime, if you have any questions at all, please feel free to call our office. The entire office is dedicated to giving you the best experience available.

If for any reason you are unable to keep your appointment, please contact us within 24 hours of your appointment to cancel or reschedule. We understand that some delays are unavoidable but please be aware that if you are 30 minutes late (or later), we will do our best to fit you in but you may have to wait or reschedule.

Thank you for choosing Dr. Robert A. Colgrove, Jr., M.D. and Vinings Surgery Center!

Sincerely,

Robert A. Colgrove, Jr., M.D. and Staff

Vinings Surgery Center

PATIENT INTAKE FORM

Date ________________

Patient Name: ____
First Middle Last

Address: ____

City: ______________________ State: ________________ Zip:________________

SSN: ______________________ (Required for surgery scheduling purposes)

Email Address: ____

Telephone: (Home) ____________ (Cellular) ____________ (Work) ____________

Are there any restrictions for contacting you? ☐ Yes ☐ No

Age: _________ Date of Birth: ___________ Gender: ☐ Male ☐ Female ☐ TG

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity: ____

HOW DID YOU HEAR ABOUT US?

☐ Best Self Magazine	☐ Ad in gym, club, restaurant	☐ Radio Station ___________
☐ The Barter Company	☐ JustBreastImplants.com	☐ RealSelf.com
☐ BreastImplantsUSA.com	☐ La Mega Mundial	☐ Internet Search
☐ ImplantForum.com	☐ YouTube	☐ Magazine
☐ ImplantInfo.com	☐ Plastic Surgery.com	☐ Other ______________

Referring Physician or Patient: ____

May we thank him/her? ☐ Yes ☐ No

Have you been to our website (www.Colgrove.com)? ☐ Yes ☐ No

If so, was our website helpful? ☐ Yes ☐ No

If NO, please list reason so we can improve this: ______________________________

EMPLOYMENT INFORMATION

Occupation: ____

☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Other

Employer/School: ______________________ Work Tel: _____________

Is it ok to contact you at work? ☐ Yes ☐ No

SPOUSE CONTACT

(if applicable)

Name: ___________________________ Spouse's Cell Tel: ___________

Spouse's Employer: ___________________ Spouse's Work Tel: __________

EMERGENCY CONTACT

(Not in your Household)

Name: _______________________________ Home Tel: _____________

Relationship to Patient: ___________________ Work Tel: _____________

Address: _____________________________ Cellular: _____________

City: ___________________ State: _________ Zip: _______________

AREAS OF INTEREST

FACE	BREAST	BODY	AESTHETICS / SKIN
☐ Brow or Forehead Lift	☐ Breast Augmentation	☐ Arm Lift	☐ Botox and/or Facial Fillers
☐ Chin Augmentation	☐ Breast Asymmetry	☐ Buttock Augmentation	☐ Body Contouring/RF
☐ Ear Pinning (Otoplasty)	☐ Breast Implant Exchange	☐ Body Lift	☐ Chemical Peel
☐ Earlobe Repair	☐ Breast Lift (Mastopexy)	☐ Cellulite Reduction	☐ IPL/Fotofacial
☐ Eyelid Lift (Blepharoplasty)	☐ Breast Reconstruction	☐ Fat Transfer	☐ Laser Hair Reduction
☐ Facelift	☐ Breast Reduction	☐ Labia Reshaping	☐ Microdermabrasion
☐ Facial Liposuction	☐ Breast Revision/Repair	☐ Liposuction	☐ Skincare products for home
☐ Fat Injections	☐ Male Breast (Gynecomastia)	☐ Thigh Lift	☐ Skin Resurfacing
☐ Lip Enhancement	☐ Nipple Reduction/Inversion	☐ Tummy Tuck	☐ Skin Tightening/Firming
☐ Neck Lift	☐ Other: ______________	☐ Other: __________	☐ Spider Veins
☐ Nose Reshaping (Rhinoplasty)			☐ Wrinkle Reduction
☐ Other: ______________	____________________		☐ Other: ______________

If you have or have had any of the following conditions or illnesses, please let us know by checking the appropriate boxes.

CARDIOVASCULAR

Condition	Yes	No
Angina/Chest Pain	☐ Yes	☐ No
Blood Pressure Abnormalities	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Heart Bypass Surgery	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No

RESPIRATORY

Condition	Yes	No
Abnormal Chest X-ray	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Cough with Mucus or Blood	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Major Allergies	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Recent Chest Infection	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Shortness of Breath at night	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Use a C-PAP Machine	☐ Yes	☐ No

GASTROINTESTINAL

Condition	Yes	No
Bloody Bowel Movements	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Gallstones	☐ Yes	☐ No
Gastritis	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No
Hiatal Hernia	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Liver Disease (Cirrhosis)	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No

ENDOCRINE

Condition	Yes	No
Diabetes	☐ Yes	☐ No
Hyperthyroidism	☐ Yes	☐ No
Hypothyroidism	☐ Yes	☐ No
Hypoglycemia	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No

PSYCHIATRIC

Condition	Yes	No
Alcoholism or Drug Dependency	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Obsessive Compulsive Disorder	☐ Yes	☐ No
Psychiatric Hospitalization/Care	☐ Yes	☐ No

NEUROLOGICAL

Condition	Yes	No
Arthritis	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Herniated Disc	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No
Palsy or Paralysis	☐ Yes	☐ No
Rheumatoid	☐ Yes	☐ No
Sciatica	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Stroke	☐ Yes	☐ No

HEMATOLOGIC/ONOCOLOGIC

Condition	Yes	No
Anemia	☐ Yes	☐ No
Bleeding Tendency or Disorder	☐ Yes	☐ No
Blood Clots in Legs	☐ Yes	☐ No
Blood Clots in Lungs	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No
Positive blood test for HIV/AIDS	☐ Yes	☐ No
Radiation Therapy	☐ Yes	☐ No
Sickle Cell Disease	☐ Yes	☐ No

SKIN

Atypical Skin Lesions	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Piercing other than Ears	☐ Yes	☐ No
Radiation	☐ Yes	☐ No
Accutane within 6 months	☐ Yes	☐ No

OTHER

Airway Obstruction (Nasal)	☐ Yes	☐ No
Kidney or Renal Disease	☐ Yes	☐ No
Missed or Irregular Period	☐ Yes	☐ No
Breast Cysts or Tumors	☐ Yes	☐ No
Fractured bones/breaks	☐ Yes	☐ No
Nipple Discharge (not from normal lactation)	☐ Yes	☐ No

EYES/MOUTH

Cataracts	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No
Glaucoma or Eye Problems	☐ Yes	☐ No
Visual Disturbances	☐ Yes	☐ No
Error in Refraction	☐ Yes	☐ No
Do you wear Contact Lenses	☐ Yes	☐ No
Cosmetic bonding to teeth	☐ Yes	☐ No
Dentures, bridges, caps or crowns	☐ Yes	☐ No
Loose teeth	☐ Yes	☐ No

Have any of your family members unexpectedly died following anesthesia or exercise? ☐ Yes ☐ No

If yes, please explain ______________________________

Do you have a family or personal history of malignant hyperthermia? ☐ Yes ☐ No

Do you have a family or personal history of a muscle or neuromuscular disorder? ☐ Yes ☐ No

Do you have a family or personal history of high temperature following exercise? ☐ Yes ☐ No

Do you have a personal history of muscles spasm? ☐ Yes ☐ No

Do you have a personal history of dark or chocolate-colored urine? ☐ Yes ☐ No

Do you have a personal history of unanticipated fever immediately following anesthesia or serious exercise? ☐ Yes ☐ No

HOSPITALIZATIONS & SURGERIES

Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons

Where	When	Why

1. Do you have an allergic reaction to any medication? ☐ Yes ☐ No Which? ________________

2. Do you react abnormally to any medication? ☐ Yes ☐ No Which? ________________

3. Are you allergic to Latex? ☐ Yes ☐ No

4. Are you allergic to Iodine? ☐ Yes ☐ No

5. Have you or any member of your family ever had any difficulties with any medications, drugs, or gases used for anesthesia? ☐ Yes ☐ No

6. Have you ever been on cortisone or steroid treatment? ☐ Yes ☐ No When? ________________

7. Do you drink alcoholic beverages including beer, wine or other alcohol regularly?
☐Yes ☐No If so, how much? ________________

8. Do you smoke or use tobacco products? ☐ Yes ☐ No
If so, how much? ________________ For how long? ________________

9. Are you pregnant? ☐ Yes ☐ No When was your last menstrual period? ________________
(You cannot have surgery if you are pregnant)

10. How many pregnancies? _______ Births? _______ Breast Fed? ☐ Yes ☐ No How long? ________

11. What form of birth control do you use? ________________

12. When was your last physical exam? ________________

13. How would you describe your health? ☐ Good ☐ Fair ☐ Poor

14. When was your last eye exam? ________________ By whom? ________________
When and where was your last CHEST X-RAY ? ________________
MAMMOGRAM?________________ EKG? ________________

15. Who is your personal physician, if any? ________________ Please list all doctors caring for you with phone number: ________________

16. Have you ever been under psychiatric care? ☐ Yes ☐ No
When? ________________ Why? ________________

17. Have you ever been diagnosed with anorexia, bulimia or any eating disorder? ☐ Yes ☐ No

18. Have you had any recent blood work done? ☐ Yes ☐ No Where? ________________

19. Do you have sleep apnea? ☐ Yes ☐ No

Vinings Surgery Center
Initial Consult Worksheet

Patient Name: ____

Yes No Are you currently taking aspirin or Advil?

Yes No Are you on Coumadin or other blood thinners?
If yes, list: ____

Yes No Are you taking diet pills, herbal supplements or energy drinks?
If yes, list: ____

Yes No Are you on hormone replacement therapy or birth control pills?

Yes No Is there anything else you think the doctor should know or are there ANY other major health concerns?
If yes, list____

Please list all present medications, including birth control pills, hormones, vitamins, herbal medications, diuretics and weight loss drugs. **Include over-the-counter medications.**

Name	Dosage	How Often Taken

FOR OFFICE USE ONLY

Height: ____________________ Blood Pressure: ____________________

Weight: ____________________ Rate: ____________________

BMI: ____________________ Initial: ____________________

Vinings Surgery Center

I agree to stop smoking 2 weeks before and 2 weeks after surgery ☐ Yes ☐ No

By signing below, I agree that the information is complete and accurate to the best of my knowledge.

Signature ____ Date ___________________________

I hereby acknowledge that a copy of Vinings Surgery Center's Notice of Privacy Practices regarding the use and disclosure of my personal health information was made available for me to review.

Date: _______________ Patient/Responsible Party Signature _____________________________________

I hereby authorize Dr. Robert A. Colgrove, Jr. to release to my insurance company or to any health care financing organization any information concerning my illness or treatment. I hereby assign to the physician all payments for medical services rendered to myself or my dependent. I permit a copy of this authorization to be used in place of the original. I have read the attached Office Policy and I understand and agree to its terms. I hereby give consent to Dr. Colgrove to take photographs of my injury or requested areas of discussion. Such pictures are to be used for scientific or educational purposes.

Date: _______________ Patient/Responsible Party Signature: ____________________________________

AUTHORIZATION FOR DISCLOSURE OF INFORMATION:

I authorize Dr. Robert Colgrove to disclose complete information concerning his medical findings and treatment of the undersigned, from the initial office visit until the date of the conclusion of such treatment, to those individuals who, in Dr. Robert A. Colgrove's sole determination, are required to receive such information *for the purpose of medical treatment, medical quality assurance and peer review.*

Patient's Signature: ___________________________________ Date: ________________________________

- ☐ After your consultation, we may mail you a survey, follow-up letter, and additional information to the postal address that you supplied. If you would prefer that we do not contact you in this way, please check this box.

May we contact you through email? If yes, please provide your email address:

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