



*Amy T. Bandy, D.O., F.A.C.S.*

*Plastic and Reconstructive Surgery*

Date: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_  
Last name First name Middle initial

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME TELEPHONE#: \_\_\_\_\_ CELL PHONE#: \_\_\_\_\_

SEX: F M AGE: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

DRIV. LIC.#: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ WORK TEL#: \_\_\_\_\_ EXT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

HOME TEL#: \_\_\_\_\_ WORK TEL#: \_\_\_\_\_ CELL PHONE#: \_\_\_\_\_

DO YOU HAVE AN ADVANCE DIRECTIVE IN EFFECT? \_\_\_\_\_ YES \_\_\_\_\_ NO

May we contact you at work during business hours? \_\_\_Yes \_\_\_No  
May we leave detailed messages at your home telephone number? \_\_\_Yes \_\_\_No

INSURANCE CO.: \_\_\_\_\_ TEL#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

INSURED SS OR ID#: \_\_\_\_\_ DOB \_\_\_\_\_ GROUP# \_\_\_\_\_

INSURED'S EMPLOYER: \_\_\_\_\_ TEL#: \_\_\_\_\_

DO YOU HAVE SECONDARY INSURANCE? Yes\_\_\_ No\_\_\_

INSURANCE CO.: \_\_\_\_\_ TEL#: \_\_\_\_\_

I have had the opportunity to review Amy T. Bandy Medical Corp./Lido Surgical Institute's Notice of Privacy Practices and the Policy on Prohibition of Harassment as required by HIPPA regulation. A copy of this notice will be provided to me at my request.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize Dr. Bandy to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to Dr. Bandy. I understand that I am responsible for charges not covered by this assignment. I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original. I certify that the information I have reported with regard to my insurance coverage is correct.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**How did you hear about Dr. Bandy?**

- Friend \_\_\_\_\_
- Patient \_\_\_\_\_
- Physician \_\_\_\_\_

**Internet Search:**

- |   |   |
|---|---|
| <input type="checkbox"/> RealSelf.com   | <input type="checkbox"/> Google.com             |
| <input type="checkbox"/> Surgery.org (American Society of Aesthetic Plastic Surgery web site) | <input type="checkbox"/> Loveyourlook.com       |
| <input type="checkbox"/> PlasticSurgery.org(American Society of Plastic Surgery web site)     | <input type="checkbox"/> Bing.com               |
| <input type="checkbox"/> Yahoo.com  | <input type="checkbox"/> Yelp.com               |
| <input type="checkbox"/> Other _____  | <input type="checkbox"/> CareCredit             |
|   | <input type="checkbox"/> Search term used _____ |

**Magazine/Newspaper:**

- |  |  |
|--|--|
| <input type="checkbox"/> Coast Magazine        | <input type="checkbox"/> Orange County Register (Best of OC) |
| <input type="checkbox"/> Orange Coast Magazine | <input type="checkbox"/> Other _____                         |

**What procedure(s) are you inquiring about today?**

**Have you met with other plastic surgeons for this type of consultation?**

**What type of plastic surgery have you had in the past, and are you happy with the results?**

**What are the most important factors to you when deciding where to have surgery?**

**Would you be interested in financing information?**

**What budget have you determined for your surgery? Estimate:**

**My time frame for surgery is:**

- As soon as possible
- Soon
- 1-3 months from now
- 6-12 months from now
- Just need information

*To better serve you, please let us know what other concerns you have that you would like more information about. Please check all that apply:*

**FACIAL:**

- |  |  |
|--|--|
| <input type="checkbox"/> Facial aging/drooping                           | <input type="checkbox"/> Torn or stretched earlobes    |
| <input type="checkbox"/> Nose reshaping                                  | <input type="checkbox"/> Eyelid lift/ Drooping eyelids |
| <input type="checkbox"/> Frown lines/ wrinkles                           | <input type="checkbox"/> Mole removal                  |
| <input type="checkbox"/> Lips shape/ thin lips                           | <input type="checkbox"/> Spider/Varicose Veins         |
| <input type="checkbox"/> Botox   | <input type="checkbox"/> Scar revision                 |
| <input type="checkbox"/> Skin care advice                                | <input type="checkbox"/> Ear size/shape                |
| <input type="checkbox"/> Facial Fillers<br>(Juvederm,Restylane,Boletero) | <input type="checkbox"/> Neck wrinkles                 |
| <input type="checkbox"/> Length of Eyelashes- Latisse                    | <input type="checkbox"/> Neck looseness/ "turkey neck" |
| <input type="checkbox"/> Chemical Peel or Laser resurfacing              | <input type="checkbox"/> Fatty neck                    |
| <input type="checkbox"/> Brown/Age spots/ freckles/ Blotchy skin         | <input type="checkbox"/> Eyebrow/forehead lift         |
| <input type="checkbox"/> Sun damage                                      | <input type="checkbox"/> Cheek/ chin augmentation      |
| <input type="checkbox"/> Hollowness in face                              |  |

**BODY:**

- Breast size/ shape/ nipple or areola reduction
- Abdomen- excess skin or fat
- "Muffin top"
- Body Contouring- liposuction
- Thick thighs/ankles
- "Brazilian Buttlift"- buttock enhancement
- Mommy makeover
- Labiaplasty- rejuvenation of genitalia
- Gynecomastia- enlarged male breasts

**SKIN CARE: (consult with an aesthetician)**

- Waxing- bikini, face, legs, mustache, under arms
- Facials: acne, deep cleansing, anti-aging, moisturizing
- Micro-dermabrasion- exfoliating
- High frequency skin treatment to increase absorption of anti-aging products
- Ultrasound treatment for face-rebuilding collagen

# Amy T. Bandy, D.O., F.A.C.S.

## Health Screening Questionnaire

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ All Previous Occupations: \_\_\_\_\_

Birth Place: \_\_\_\_\_ Birthdate: \_\_\_\_\_ List all states in which you have lived: \_\_\_\_\_

Education History: High School:  College:  Post-Grad:  Marital Status:  
 (Indicate Number of Years) Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widow(er) \_\_\_

Date of last physical examination: \_\_\_\_\_ List current medication, neurtaceutical and herb dosages: \_\_\_\_\_

**PERSONAL HISTORY:** (please circle all answers)

**Has ANY blood relative ever had**

Bleeding disorder \_\_\_\_\_ No Yes  
 Deep Vein Thrombosis \_\_\_\_\_ No Yes  
 Pulmonary Embolism \_\_\_\_\_ No Yes  
 Blood Clots \_\_\_\_\_ No Yes  
 Anesthesia Complications \_\_\_\_\_ No Yes

**Have YOU ever had**

Bleeding disorder \_\_\_\_\_ No Yes  
 Deep Vein Thrombosis \_\_\_\_\_ No Yes  
 Pulmonary Embolism \_\_\_\_\_ No Yes  
 Blood Clots \_\_\_\_\_ No Yes  
 Anesthesia Complications \_\_\_\_\_ No Yes  
 Unexplained fainting spell \_\_\_\_\_ No Yes  
 Unexplained shortness of  
 breath \_\_\_\_\_ No Yes  
 Thrombophlebitis \_\_\_\_\_ No Yes  
 Venous insufficiency \_\_\_\_\_ No Yes  
 Cancer \_\_\_\_\_ No Yes  
 Nephrotic Syndrome \_\_\_\_\_ No Yes  
 Antiphospholipid Syndrome \_\_\_\_\_ No Yes  
 Lupus \_\_\_\_\_ No Yes  
 Polycythemia \_\_\_\_\_ No Yes  
 Homocystinemia \_\_\_\_\_ No Yes  
 Radiation Therapy \_\_\_\_\_ No Yes

**ILLNESSES: Have you ever had**

Measles \_\_\_\_\_ No Yes  
 German Measles \_\_\_\_\_ No Yes  
 Mumps \_\_\_\_\_ No Yes  
 Chicken Pox \_\_\_\_\_ No Yes  
 Whooping Cough \_\_\_\_\_ No Yes  
 Scarlet Fever or  
 Scarletina \_\_\_\_\_ No Yes  
 Diphtheria \_\_\_\_\_ No Yes  
 Small Pox \_\_\_\_\_ No Yes  
 Pneumonia \_\_\_\_\_ No Yes  
 Influenza \_\_\_\_\_ No Yes  
 Pleurisy \_\_\_\_\_ No Yes  
 Rheumatic fever or  
 Heart disease \_\_\_\_\_ No Yes  
 Arthritis or  
 Rheumatism \_\_\_\_\_ No Yes  
 Any bone or  
 joint disease \_\_\_\_\_ No Yes  
 Neuritis or neuralgia \_\_\_\_\_ No Yes  
 Bursitis, Sciatica or  
 Lumbago \_\_\_\_\_ No Yes  
 Polio or Meningitis \_\_\_\_\_ No Yes  
 Nephritis \_\_\_\_\_ No Yes

HPV, HSV I or II \_\_\_\_\_ No Yes  
 Cold sores or Fever blisters \_\_\_\_\_ No Yes  
 Heart Murmur \_\_\_\_\_ No Yes  
 Gonorrhea or Syphilis \_\_\_\_\_ No Yes  
 Gallbladder disease \_\_\_\_\_ No Yes  
 Jaundice \_\_\_\_\_ No Yes  
 Bladder disease \_\_\_\_\_ No Yes  
 Epilepsy \_\_\_\_\_ No Yes  
 Migraine headaches \_\_\_\_\_ No Yes  
 Tuberculosis \_\_\_\_\_ No Yes  
 Diabetes \_\_\_\_\_ No Yes  
 High or low blood pressure \_\_\_\_\_ No Yes  
 Colitis or other  
 bowel disease \_\_\_\_\_ No Yes  
 Hemorrhoids or any  
 rectal disease \_\_\_\_\_ No Yes  
 Anemia \_\_\_\_\_ No Yes  
 Nervous Breakdown \_\_\_\_\_ No Yes  
 Graves disease \_\_\_\_\_ No Yes  
 Rosacea \_\_\_\_\_ No Yes  
 Pemphigus \_\_\_\_\_ No Yes  
 Thyroid disease \_\_\_\_\_ No Yes  
 Eye disease \_\_\_\_\_ No Yes  
 What type \_\_\_\_\_  
 Food, chemical or drug  
 Poisoning \_\_\_\_\_ No Yes  
 Hay fever or Asthma \_\_\_\_\_ No Yes  
 Hives or Eczema \_\_\_\_\_ No Yes  
 Frequent infections or boils \_\_\_\_\_ No Yes  
 Any other disease \_\_\_\_\_ No Yes  
 If yes please list \_\_\_\_\_

Test positive for HIV \_\_\_\_\_ No Yes  
 Hepatitis A, B or C \_\_\_\_\_ No Yes

**HAVE YOU EVER BEEN  
 DIAGNOSED**

Clinical depression \_\_\_\_\_ No Yes  
 Obsessive-compulsive  
 disorder \_\_\_\_\_ No Yes  
 Schizophrenia \_\_\_\_\_ No Yes  
 Personality disorder \_\_\_\_\_ No Yes  
 Other psychiatric disorder \_\_\_\_\_ No Yes

**ALLERGIES: Are you allergic to**

Penicillin or Sulfa \_\_\_\_\_ No Yes  
 Aspirin, Codeine or  
 Morphine \_\_\_\_\_ No Yes

Mycins or other Antibiotics \_\_\_\_\_ No Yes  
 Merthiolate or  
 Mercurochrome \_\_\_\_\_ No Yes  
 Any other drug \_\_\_\_\_ No Yes  
 Any foods \_\_\_\_\_ No Yes  
 Adhesive Tape \_\_\_\_\_ No Yes  
 Latex \_\_\_\_\_ No Yes  
 Nail Polish or other  
 Cosmetics \_\_\_\_\_ No Yes  
 Tetanus Antoxin or Serums \_\_\_\_\_ No Yes

**HEIGHT & WEIGHT:**

Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Weight one year ago \_\_\_\_\_  
 Maximum \_\_\_\_\_ When \_\_\_\_\_

**TRANSFUSION: Have you ever had**

Blood or Plasma Transfusion \_\_\_\_\_ No Yes

**INJURIES: Have you had any**

Broken or cracked bones \_\_\_\_\_ No Yes  
 Sprains \_\_\_\_\_ No Yes  
 Lacerations \_\_\_\_\_ No Yes  
 Dislocations \_\_\_\_\_ No Yes  
 Concussions or head injury \_\_\_\_\_ No Yes  
 Ever been knocked  
 Unconscious \_\_\_\_\_ No Yes

**SMOKING:**

Do you smoke now \_\_\_\_\_ No Yes  
 If so, how much each day \_\_\_\_\_  
 How long have you smoked \_\_\_\_\_  
 If you don't smoke, have you  
 ever in the past \_\_\_\_\_ No Yes  
 For how many years \_\_\_\_\_  
 When did you quit? \_\_\_\_\_

**SURGERY: Have you had**

Tonsillectomy \_\_\_\_\_ No Yes  
 Appendectomy \_\_\_\_\_ No Yes  
 Any other operation \_\_\_\_\_ No Yes  
 Type \_\_\_\_\_ Year \_\_\_\_\_  
 Type \_\_\_\_\_ Year \_\_\_\_\_  
 Have you ever been advised to have any  
 surgical operation that has not been  
 done \_\_\_\_\_ No Yes  
 Have you ever been hospitalized?  
 For any illness? \_\_\_\_\_ No Yes

**DO YOU HAVE OR HAVE HAD WITHIN THE PAST YEAR**

Frequent or severe headaches \_\_\_\_\_ No Yes  
 Fainting spells \_\_\_\_\_ No Yes  
 Dizziness on change of position \_\_\_\_\_ No Yes  
 Unconscious spells \_\_\_\_\_ No Yes  
 Blurred vision \_\_\_\_\_ No Yes  
 Double vision \_\_\_\_\_ No Yes  
 Infected eyes \_\_\_\_\_ No Yes  
 Pain behind eyes \_\_\_\_\_ No Yes  
 Any change in vision \_\_\_\_\_ No Yes  
 Do you wear glasses? \_\_\_\_\_ No Yes  
 When were they last checked? \_\_\_\_\_  
 Earaches \_\_\_\_\_ No Yes  
 Recurrent nose bleeds \_\_\_\_\_ No Yes  
 Recurrent head colds \_\_\_\_\_ No Yes  
 Sinus trouble \_\_\_\_\_ No Yes  
 Hay fever \_\_\_\_\_ No Yes  
 Persistent hoarseness \_\_\_\_\_ No Yes  
 Difficulty swallowing \_\_\_\_\_ No Yes  
 Enlarged glands \_\_\_\_\_ No Yes  
 Recurrent sore throats \_\_\_\_\_ No Yes  
 Recurrent sores in mouth \_\_\_\_\_ No Yes  
 Soreness or bleeding of gums on brushing \_\_\_\_\_ No Yes  
 Chest pain \_\_\_\_\_ No Yes  
 Angina pectoris \_\_\_\_\_ No Yes  
 Coughed up blood \_\_\_\_\_ No Yes  
 Pain in arm(s) \_\_\_\_\_ No Yes  
 Night sweats \_\_\_\_\_ No Yes  
 Chronic or frequent cough \_\_\_\_\_ No Yes  
 Chronic or frequent cough on laying down \_\_\_\_\_ No Yes  
 Wake up at night short of breath \_\_\_\_\_ No Yes  
 How many bed pillows do you use? \_\_\_\_\_  
 Do you have dry eyes? \_\_\_\_\_ No Yes  
 Excessive tear production \_\_\_\_\_ No Yes  
 Shortness of breath on:  
 Walking several blocks \_\_\_\_\_ No Yes  
 One flight of stairs \_\_\_\_\_ No Yes  
 On laying down \_\_\_\_\_ No Yes  
 Purple lips or fingers \_\_\_\_\_ No Yes  
 Palpitations or fluttering of heart \_\_\_\_\_ No Yes  
 High blood pressure \_\_\_\_\_ No Yes  
 Swelling of hands, feet or ankles \_\_\_\_\_ No Yes  
 At what time of the day \_\_\_\_\_  
 Leg cramps on walking or at night \_\_\_\_\_ No Yes  
 Enlarged veins in legs \_\_\_\_\_ No Yes  
 Recurrent stomach pain \_\_\_\_\_ No Yes  
 Belching or heartburn \_\_\_\_\_ No Yes  
 Relieved by food or medication \_\_\_\_\_ No Yes  
 Appetite – Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_  
 Nausea or vomiting \_\_\_\_\_ No Yes  
 Vomiting blood \_\_\_\_\_ No Yes  
 Abdominal cramping \_\_\_\_\_ No Yes  
 Color of bowel movement \_\_\_\_\_  
 Any blood in BM \_\_\_\_\_ No Yes  
 Rectal pain with bowel movement \_\_\_\_\_ No Yes

**MENSTRUAL HISTORY:**

Age at onset \_\_\_\_\_ Regular? Yes \_\_\_\_\_ No \_\_\_\_\_ Varies \_\_\_\_\_  
 Date of last period \_\_\_\_\_ Date of last pelvic exam \_\_\_\_\_  
 Date of last Pap test \_\_\_\_\_ Results: Neg \_\_\_\_\_ Pos \_\_\_\_\_  
 Do you take birth control pills? \_\_\_\_\_ No Yes  
 How long have you taken them \_\_\_\_\_  
 Pregnancies: How many children born alive \_\_\_ still \_\_\_ premature \_\_\_  
 How many Cesarean Sections \_\_\_\_\_  
 How many miscarriages \_\_\_\_\_

**DO YOU HAVE OR HAVE HAD WITHIN THE PAST YEAR**

Change in size, shape or texture of BM \_\_\_\_\_ No Yes  
 Describe \_\_\_\_\_  
 Pain on urinating \_\_\_\_\_ No Yes  
 Difficulty in starting urination \_\_\_\_\_ No Yes  
 Do you get up at night to urinate? \_\_\_\_\_ No Yes  
 How many times \_\_\_\_\_  
 Urinate more than before \_\_\_\_\_ No Yes  
 Any blood in urine \_\_\_\_\_ No Yes  
 Full feeling of bladder, but only small amounts of urination \_\_\_\_\_ No Yes  
 Lose urine on coughing or sneezing \_\_\_\_\_ No Yes  
 Discharge from penis/vagina \_\_\_\_\_ No Yes  
 Recurrent back pains \_\_\_\_\_ No Yes  
 Backaches \_\_\_\_\_ No Yes  
 Joint pains \_\_\_\_\_ No Yes  
 Swelling of any joints \_\_\_\_\_ No Yes  
 Redness or heat of any joint \_\_\_\_\_ No Yes  
 Tingling or weakness of hands or feet \_\_\_\_\_ No Yes  
 Muscle spasm \_\_\_\_\_ No Yes  
 Loss or change in sensation of hand or feet \_\_\_\_\_ No Yes  
 Trembling of any extremity \_\_\_\_\_ No Yes  
 Growth in neck or throat \_\_\_\_\_ No Yes  
 Hot flashes \_\_\_\_\_ No Yes  
 Tiredness without any apparent reason \_\_\_\_\_ No Yes  
 Brittleness of nails \_\_\_\_\_ No Yes  
 Dryness of skin \_\_\_\_\_ No Yes  
 Easy bruising \_\_\_\_\_ No Yes  
 Inability to stand heat \_\_\_\_\_ No Yes  
 Inability to stand cold \_\_\_\_\_ No Yes  
 Change in hair texture \_\_\_\_\_ No Yes  
 Any skin rash \_\_\_\_\_ No Yes

**HAVE YOU EVER HAD X-RAYS OF:**

Chest \_\_\_\_\_ No Yes  
 Stomach or colon \_\_\_\_\_ No Yes  
 Gall bladder \_\_\_\_\_ No Yes  
 Extremities \_\_\_\_\_ No Yes  
 Back \_\_\_\_\_ No Yes  
 Teeth \_\_\_\_\_ No Yes  
 Other \_\_\_\_\_ No Yes

**EKG:** Ever had an electrocardiogram \_\_\_\_\_ No Yes

**IMMUNIZATION: Have you had?**

Tetanus shots in last 5 years (not antitoxin that lasts only 2 weeks) \_\_\_\_\_ No Yes  
 Polio shots within the last 2 years \_\_\_\_\_ No Yes

**MEDICATIONS:**

Laxatives never \_\_\_\_\_ occ \_\_\_\_\_ freq \_\_\_\_\_ daily \_\_\_\_\_  
 Vitamins never \_\_\_\_\_ occ \_\_\_\_\_ freq \_\_\_\_\_ daily \_\_\_\_\_  
 Sedatives never \_\_\_\_\_ occ \_\_\_\_\_ freq \_\_\_\_\_ daily \_\_\_\_\_  
 Tranquilizers never \_\_\_\_\_ occ \_\_\_\_\_ freq \_\_\_\_\_ daily \_\_\_\_\_  
 Sleeping pills, etc. never \_\_\_\_\_ occ \_\_\_\_\_ freq \_\_\_\_\_ daily \_\_\_\_\_  
 Aspirin, etc. never \_\_\_\_\_ occ \_\_\_\_\_ freq \_\_\_\_\_ daily \_\_\_\_\_  
 Cortisone, Acet. never \_\_\_\_\_ occ \_\_\_\_\_ freq \_\_\_\_\_ daily \_\_\_\_\_  
 Thyroid never \_\_\_\_\_ yes in the past, none now \_\_\_\_\_  
 Daily appetite depressants daily \_\_\_\_\_ now on \_\_\_\_\_  
 Have you ever been treated for drug habits? \_\_\_\_\_ No Yes  
 Have you ever been treated for alcohol related problems? \_\_\_\_\_ No Yes  
 Have you ever taken insulin or tablets for diabetes? \_\_\_\_\_ No Yes  
 Have you ever taken hormone tablets or injections? \_\_\_\_\_ No Yes

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Bandy will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.