Surgical Friends Foundation

465 N. Roxbury Drive, Suite 1001, Beverly Hills, CA 90210
Tel: (310) 777-8880 ◆ Fax: (310) 248-6258
www.Surgicalfriends.org

Date: _____

Name: _____ Age: _____ DOB: _____/_____/_____

Address: _____ Home Tel: (_____)_____

City _____State_____ Zip Code_____ __Cell Tel: (_____)_____

Name of the person filling this application: _____relationship to patient_____

Address:_____City_____State_____Zip Code_____

Telephone Number:_____ Email:_____

Please make sure you read all the requirements on our website before submitting this application. Surgical Friends Foundation does not perform any cosmetic surgery. Your application will not be considered if you are in need of such services.

How did you hear about Surgical Friends Foundation? _____

All patients that are selected for surgery **may** be filmed and may be featured on documentaries or their story televised on national television, would you be ok with that? _____

Please tell us about your condition and how it has affected you. Also include any documents and pictures related to your condition. If you need additional space please attach a separate document:

_____

_____

_____

_____

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_____

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_____

Please describe what kind of procedure you are interested in having:_____

_____

_____

_____

_____

Have you consulted with other physicians about procedure(s) indicated above: ☐No ☐Yes

If Yes, please describe your understanding of the procedure(s)_____

Is this procedure a revision from a previous surgery ☐No ☐Yes If yes, how many previous surgeries?_____

What is your "ideal time frame" for procedure(s) completion _____

Employer _____ Address _____

Occupation: _____ Marital Status: _____

Primary Insurance Co (if applicable) _____ Policy # _____

Group # _____ Name of person insured _____ SS# _____

Eligibility Phone # _____ Copay _____

Secondary Insurance Co. _____ Policy # _____

Group # _____ Name of person insured _____ SS# _____

Eligibility Phone # _____ Copay _____

HEALTH INFORMATON

Personal Past History:

Do you have any chronic medical problems? (Circle all that apply)

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Psychiatric Diagnosis	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attack	Liver Disease	Emphysema
Chest Pain	Gastric Reflux	Stomach Problems
	Asthma	Other _____

Is there a personal or family history of anesthetic complications? ☐No ☐Yes

If yes, please explain_____

_____

_____

_____

_____

_____

Family History:
Do you have a family history of any medical problems? (Circle all that apply) Please indicate family member.

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Psychiatric Diagnosis	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attack	Liver Disease	Emphysema
Chest Pain	Gastric Reflux	Stomach Problems
	Asthma	Other _____

Please list all prior operations:	Date	List any complications
1._____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Please list all prior Hospitalizations:	Date	List any complications
1._____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Please list **ALL** medications and/or dietary supplements including:
(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

Please list **ALL** allergies and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc).

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Social History:

Have you ever used tobacco products? ☐No ☐Yes If yes, how long?_____ how much?_____
Which tobacco product(s) have you used?_____
If you are a former smoker, state the year you stopped: _____

Past or current use of Nicotine Gum, Patch, or any other type of stop-smoking aid: ☐No ☐Yes
If yes, please list: _____

Alcohol Consumption: _____Never (Do not consume alcohol) _____ Rare (1-2 drinks a week)

_____ Moderate (7-10 drinks a week) _____ Heavy (daily or more than 10 drinks a wk)

Did you ever drink heavily in the past? ☐No ☐Yes

Are you feeling hopeless about the present/future? ☐No ☐Yes

Do you currently have thoughts of harming yourself? ☐No ☐Yes

Additional comments or concerns:

Review of Systems:

Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR

High Blood Pressure	Y ___ N ____	Heart Failure	Y ___ N ____
Heart Attack	Y ___ N ____	Irregular Heartbeat	Y ___ N ____
Angina/chest pain	Y ___ N ____	Heart Murmur	Y ___ N ____
Heart bypass surgery	Y ___ N ____	Do you exercise?	Y ___ N ____
Pacemaker	Y ___ N ____	Comments: _____	

NEUROLOGICAL

Stroke	Y ___ N ____
Seizures	Y ___ N ____
Fainting	Y ___ N ____
Dizziness	Y ___ N ____
Headache	Y ___ N ____
Double Vision	Y ___ N ____

PSYCHIATIC

Depression	Y ___ N ____
Anxiety	Y ___ N ____
Psychiatric Care	Y ___ N ____
Obsessive Compulsive Disorder	Y ___ N ____

ENDOCRINE

Diabetes	Y ___ N ____
Thyroid Disease	Y ___ N ____
Taken Steroids	Y ___ N ____

HEMATOLOGIC/ONCOLOGIC/

Bleeding Tendency	Y ___ N ____
Easy Bruising	Y ___ N ____
Anemia	Y ___ N ____
Sickle Cell Disease	Y ___ N ____
Blood clots in legs	Y ___ N ____
Blood clots in lungs	Y ___ N ____
Radiation Therapy	Y ___ N ____

URINARY/REPRODUCTIVE

Kidney Disease	Y ___ N ____
Urinary Disease	Y ___ N ____
Dialysis	Y ___ N ____
If Female, could you be preg?	Y ___ N ____

Number of live births_____

Number of pregnancies _____

Date of last mammogram _____

Date of date of menses (period)_____

RESPIRATORY

Abnormal Chest X-ray	Y ___ N ____
Asthma	Y ___ N ____
Bronchitis	Y ___ N ____
Emphysema	Y ___ N ____
Recent Chest Infection	Y ___ N ____
Shortness of Breath	Y ___ N ____
Shortness of Breath at night	Y ___ N ____
Shortness of Breath on exertion	Y ___ N ____
Cough	Y ___ N ____
Cough with Sputum	Y ___ N ____
Sleep Apnea	Y ___ N ____
-Use a C-PAP Machine	Y ___ N ____

MUSCULOSKELETAL

Sciatica	Y ___ N ____
Herniated disc	Y ___ N ____
Arthritis	Y ___ N ____
Rheumatoid	Y ___ N ____
Neck, Back, Arm,Leg Prob	Y ___ N ____

INFECTIOUS

GASTROINTESTINAL

Jaundice	Y ___ N ____
Hepatitis	Y ___ N ____
Ulcers	Y ___ N ____
Hiatal Hernia	Y ___ N ____
Heartburn	Y ___ N ____

SKIN

Basal cell skin cancer	Y ___ N ____
Melanoma	Y ___ N ____
Staph Infection	Y ___ N ____

EYES

Cataracts	Y ___ N ____
Glaucoma	Y ___ N ____

ASSIGNMENT AND RELEASE

I, the undersigned have read this document and the information provided in this document is true.

_____ _____

Signature of Insured/Guardian Date

_____ _____

Patient's Signature Date