Provider: ______

AQUA

MEDICAL HISTORY

ABOUT DR. DEV VIBHAKAR-

Cosmetic and reconstructive surgery is where "art" and "science" blend to combine intuition, creativity and artistic sense with extensive surgical training, discipline and medical knowledge.

Dr. Dev Vibhakar performs cosmetic surgery, body contouring and is fellowship trained at Harvard Medical School-Massachusetts General Hospital in adult facial aesthetics and reconstructive surgery. He also has specialized training in reconstructive surgery for birth defects, traumatic injuries and deformities from cancer including microsurgery and breast reconstruction.

Dr. Dev Vibhakar is committed to fully educating his patients about their individual procedures and will spend the time necessary to discuss all possible techniques and alternatives. His goal is to provide exceptional and natural appearing results on a consistent basis. He is privileged to have trained in programs that treat patients from all parts of the United States and from numerous countries around the world.

In his quest to ensure that his patients receive the benefits of the latest technologies and advances in cosmetic and reconstructive surgery, Dr. Dev Vibhakar routinely attends seminars, training and continuing medical education courses. He has been invited to lecture at national meetings on topics that involve facial skeletal augmentation and reconstruction of skull defects.

Name: ______________________________SS#: _____________________Date: ________
Street Address____
City___________________State__________Zip______________________________
Birthday: ___________________Age_______Sex_______Height_______Weight______
Cell phone ________________________Home phone___________________________
In case of emergency notify____________________Relationship________________
Telephone____

Email:____

May we send you email including news and specials about the practice? Yes No
May we request you on facebook? Yes No

Family Doctor: _______________________Location____________________________

Occupation:____
Employer: ___________________________Employer phone: _________________________
Employer address: ____

How were you referred to our office?

What is reason for your visit today? (Your concerns are very important to us. Please describe any concerns you would like the doctor or staff to discuss with you today)

Have you consulted with any other physician about this? If yes, whom?

List all **Medications** you currently take including **Herbal Supplements**/vitamins?

List any **Allergies** you have:

List past & current **Medical Problems**:

Describe all prior **Hospitalizations** & dates:

Past Surgical History

List any **Surgeries** you have had & dates:

Social History

Do you smoke? Yes No If yes, how many cigarettes/day?__________

Did you smoke in the past? Yes No If yes, how many for how long?___________

Do you drink alcohol? Yes No If yes, how many drinks per week? ________Do you take drugs not prescribed by a doctor? Yes No

Past/Current Medical History (check all that applies and describe above)

__ Anxiety	__ Embolism	__ Skin Disorder	__ Endocrine Disorder
__ Arthritis	__ Ear Problem	__ Stroke	__ Psychiatric
__ Asthma	__ Eye Problem	__ Thyroid Problem	__ Breast Problem
__ Bleeding Problem	__ Drug Dependance	__ Keloids	__ Intestinal Problem
__ Bladder Problem	__ Epilepsy	__ Kidney Problem	__ Muscle Disorder
__ Blood Clots	__ Hernia	__ Liver Problem	__ Bone Disorder
__ Bruise Easily	__ HIV/AIDS	__ Lung Problem	__ Fractures
__ Cancer	__ Infections	__ High Blood Pressure	__ Vascular Problem
__ Diabetes	__ Heart Attack (MI)	__ Neurologic Disorder	
__ Depression	__ Heart Problem	__ Seizure	__

Review of Systems:

Check any of the following that you have had **recently**:

__Fever/Chills	__Pain	__Bleeding	__Weight Loss
__Sore Throat	__ Redness	__Itching	__Vision Changes
__Cough	__Swelling	__Weakness	__Feeling Tired

__ Other: ____

Do you **scar** easily, or are you prone to hypertrophic or keloid scarring? Yes No

If you were injured, did it occur at work?

Family History

Is there **any** history of medical problems in your family? (For women, please include any history of breast cancer or disease)

Females: (if applicable)
Are you pregnant or possibly pregnant? Yes No
# of pregnancies_____ # of children_____
Do you have any history of breast disease or breast cancer? Yes No
Do you have any acute or chronic Breast Pain, Lumps, Discharge? Yes No
What was the date and findings of your last mammogram?

Have you had **Radiation Therapy** and/or **Chemo Therapy** in the past? (please describe) Yes No

Past Anesthesia History

Have you had **Anesthesia** in the past? Yes No What type of anesthesia? Local General
Describe any problems?

Are you interested in learning more about any of the following Aqua Med Spa procedures:

__ Botox
__ Laser Hair Removal
__ Laser Tattoo Removal
__ Laser Skin Resurfacing
__ Laser Skin Tightening
__ Laser Photofacials (Pigment Removal/IPL)
__ Laser Vein Removal
__ Acne Treatments
__ Skin Care Products
__ HCG Weight loss Program
__ **COOLSCULPTING**
__ Eyelash Enhancement
__ Permanent Make-up
__ Peels or Facials
__ Scar Revisions
__ Vibradermabrasion (Microdermabrasion)
__ Juvederm
__ Sculptra
__ Restylane
__ Radiesse
__ **ULTHERAPY**
__ Other: ____

The web is becoming a key way patients learn about our practice. Do you participate in any of the following? (check all that apply)

- Yelp
- Facebook
- Twitter
- RealSelf
- Blogging: If yes, where can we see it? http://_______________

(2) What website(s) did you find helpful to use in researching our practice or the procedure?

Notice of Privacy Practices Acknowledgement

I have reviewed a copy of Dr. Rankin's Notice of Privacy Practices.
(If you desire a printed copy of the notice, please notify the receptionist.)

X________________________________ ________________
Patient Signature or Legal Representative **Date**

AQUA
PLASTIC SURGERY

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Aqua Plastic Surgery
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Jupiter, Florida 33459
Phone: 561-776-2830
Fax: 561-296-4156

PHOTOGRAPHY CONSENT

"I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in **examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc."**

____________________________ **PATIENT SIGNATURE**

____________________________ **WITNESS SIGNATURE**

____________________________ **DATE**

The Board requires that all identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, be blanked out for submission of materials for the Oral Examination of The American Board of Plastic Surgery to protect patient privacy.

****PLEASE NOTE: THIS FORM MUST BE SIGNED IN ORDER TO HAVE ANY PROCEDURE PERFORMED**