

Today's Date:		
PATIENT INFORMATION		
Last name:	First Name:	Middle:
Marital Status: (Check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Date of Birth: Age: Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		Height: Weight:
City:	State:	Zip:
Social Security Number:	Home Phone:	Cell Phone:
E-mail Address:		
Occupation:	Employer:	Employer Address: Employer Phone:
How did you hear about us?		
Other family members seen here:		
MEDICAL INFORMATION		
(Please give your insurance card to the receptionist.)		
Reason for visit:		
Pharmacy:	Address:	Pharmacy Phone:
Physician Requesting Consultation:	Requesting Physician's Address:	Requesting Physician's Phone:
Primary Care Physician (PCP):		Send Report: <input type="checkbox"/> Yes <input type="checkbox"/> No
PCP's Address:	PCP's Phone:	PCP's Fax:
IN CASE OF EMERGENCY		
Name:	Relationship to patient:	Contact Number:
HEALTH HISTORY		
Do you smoke or chew tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No How much? _____	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No How much? _____	Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTH HISTORY (CONTINUED)

Please list all medicine you are currently taking: Prescription and over-the-counter medications (examples: aspirin, antacids) and dietary supplements (example: vitamins) and herbals (examples: ginseng, gingko). Include any medications taken as needed (example: inhaler, EpiPen).

Medication Name	Dose (How much?)	Frequency (How often?)

<p>Please list all allergies:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Are you allergic to Latex?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Are you currently experiencing any of the following symptoms?</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> None</td> <td><input type="checkbox"/> Diarrhea</td> <td><input type="checkbox"/> Rectal Bleeding</td> </tr> <tr> <td><input type="checkbox"/> Bleeding</td> <td><input type="checkbox"/> Dizziness</td> <td><input type="checkbox"/> Ringing in the Ears</td> </tr> <tr> <td><input type="checkbox"/> Blind Spells</td> <td><input type="checkbox"/> Dry Eyes</td> <td><input type="checkbox"/> Severe Headaches</td> </tr> <tr> <td><input type="checkbox"/> Breast Pain</td> <td><input type="checkbox"/> Fainting Spells</td> <td><input type="checkbox"/> Severe Indigestion</td> </tr> <tr> <td><input type="checkbox"/> Chest Pain</td> <td><input type="checkbox"/> Fever</td> <td><input type="checkbox"/> Shortness of Breath</td> </tr> <tr> <td><input type="checkbox"/> Chronic Cough</td> <td><input type="checkbox"/> Jaundice</td> <td><input type="checkbox"/> Spitting up Blood</td> </tr> </table>	<input type="checkbox"/> None	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Ringing in the Ears	<input type="checkbox"/> Blind Spells	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Severe Headaches	<input type="checkbox"/> Breast Pain	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Severe Indigestion	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Fever	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Spitting up Blood
<input type="checkbox"/> None	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Rectal Bleeding																		
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Ringing in the Ears																		
<input type="checkbox"/> Blind Spells	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Severe Headaches																		
<input type="checkbox"/> Breast Pain	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Severe Indigestion																		
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Fever	<input type="checkbox"/> Shortness of Breath																		
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Spitting up Blood																		

Please check if you have or ever had any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dentures | <input type="checkbox"/> HIV | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Implants/Artificial | <input type="checkbox"/> Prolonged Bleeding |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emotional Disorder | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Recent Cold |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> GI Disorder | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Swollen Ankle |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Colon Disease | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other: |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Painful Joints | |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Pacemaker | |

Family History – List any medical conditions of immediate family:

Have you ever had any serious illnesses, past surgeries or hospitalizations? Yes No

If yes, please describe and list dates:

The above information is true to the best of my knowledge. If applicable, I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance, co-pay and/or deductible. I also authorize Salman Ashruf, MD, or the insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____

Salman Ashruf, M.D., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have been made aware of a Notice of Privacy Practices for Salman Ashruf, M.D., P.A. If you have any questions, please contact the Privacy Officer whose name and contact information is listed below.

Please Print Name of Patient or Personal Representative

Patient or Personal Representative Signature

Date

Personal Representative's Relationship or Authority

Privacy Officer:

Salman Ashruf, M.D., P.A.
7550 Teague Road, Suite 105
Hanover, MD 21076
Tel: (410) 590-4313
Fax: (410) 690-7743

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify): _____

Salman Ashruf, M.D.
7550 Teague Road, Suite 105 Hanover, MD 21076
Tel: (410) 590-4313 Fax: (410) 690-7743

E-mail: doc@drashruf.com

www.drashruf.com

MY CONSULTATION GOALS

Name: _____	Date: _____
ID Number: _____	Date of Birth: _____
How did you hear about us?	

1) Please list the top 3 problems on your "Hit List" that you would like to see improved after surgery (you may list fewer):

FACE

BODY

- 1) _____
- 2) _____
- 3) _____

- 1) _____
- 2) _____
- 3) _____

2) Please list the next 3 concerns (if applicable) you would want to address during your consultation:

1. _____
2. _____
3. _____

3) What adjective(s) best describe your face or body now?

For example: **FACE:** rested, youthful, fresh **OR** tired, angry, sad, droopy, wrinkly, etc.

BODY: tight, firm, balanced **OR** droopy, saggy, loose, disproportionate, etc.

FACE: _____

BODY: _____

Approximate Measurements in Inches:

WAIST _____ **HIPS** _____

4) GOALS : What is it you need to see when you look in the mirror in order to be happy after surgery?

5) If you have surgery, how much downtime and/or time off work can you devote to your recovery?

_____ week(s)

6) What non-surgical skin concerns bother you?

- Wrinkles Pores Texture Brown Pigmentation
 Dark Circles Cellulite Red Vessels Other: _____

8) What non-surgical treatments have you had?

- Botox Filler (Restylane/Juvederm ect) IPL/Laser Fotofacial
 Laser Hair Removal Cellulite Treatments Thermage/ Laser Tightening
 Fraxel/Laser Resurfacing Other: _____

9) What is your treatment budget?

- Up to \$500 \$500 - \$1500 \$1500-\$2500 \$2500-\$5000 \$5000-\$7500 \$7500 and Up

Patient's Name (Please print)

Date

Patient's Signature

MD Signature