DR. CECILIA FANCO-WEBB @ BOD:EVOLVE

(303) 680-8989

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Preferred Name _____

Best Number to Contact: _____ E-mail _____

Contact Restrictions: _____

Age _____ Birthdate / / - - Gender ◯ Female ◯ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ◯ Yes ◯ No

Address _____
Street & Suite # City State Zip

How did you hear about bod:evolve (Mark all that apply)

❒ Internet: _____ ❒ Radio: _____ ❒ Charity Event: _____

❒ Magazine: _____ ❒ Newsletter: _____ ❒ Seminar: _____ ❒ Salon: _____

❒ Patient: _____ ❒ Doctor: _____ ❒ Other: _____

Emergency Contact

_____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Areas of Interest: (mark all that apply)

Facial Procedures

❒ Blepharoplasty (Eyelid Lift)
❒ Face or Neck Lift
❒ Brow or Forehead Lift
❒ Rhinoplasty (Nose Reshaping)
❒ Facial Liposuction (Neck, Jowls)

Breast Procedures

❒ Breast Augmentation
❒ Breast Reconstruction
❒ Breast Reduction
❒ Mastopexy (Breast Lift)
❒ Nipple Reduction or Inversion

Other Procedures

❒ Skin Care
❒ Botox
❒ Telangectasia (spider veins)
❒ Laser Hair Removal
❒ Skin Resurfacing

❒ Otoplasty (Ear Pinning)

Body Procedures

❒ Abdominoplasty (Tummy Tuck)

❒ Brachioplasty (Arm Lift)

❒ Liposuction (Abdomen, Thighs, Etc.)

❒ Leg Veins (varicose veins)

❒ Wrinkle Fillers (injections)

I understand that office visit charges are payable on the day service is rendered.

Signature _____ **Date** _____

DR. DAVID BROADWAY @ BOD:EVOLVE

(303) 680-8989

9777 South Yosemite Street Suite 200, Lone Tree, CO 80124

Health Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient:			
DOB	Age	Marital Status	Weight lbs
What surgery are you considering?			Height ft in

DO YOU NOW OR HAVE YOU EVER HAD…….. (You must circle an answer for each individual item)

Heart Trouble	Yes No	Glaucoma or Eye Problems	Yes No
Heart Attack	Yes No	Visual Disturbances	Yes No
Heart Pain	Yes No	Error in Refraction	Yes No
Palpitation or Irregular Pulse	Yes No	Other Eye Problems	Yes No
Extra Heart Beats	Yes No	Hepatitis	Yes No
Stroke	Yes No	Yellow Jaundice	Yes No
Hypertension	Yes No	Gallstones or Gallbladder Trouble	Yes No
Blood Pressure Abnormalities	Yes No	Cirrhosis of the Liver	Yes No
Abnormal EKG	Yes No	Alcoholism or Drug Dependency	Yes No
Rheumatic Fever	Yes No	Esophageal Varices	Yes No
Dropsy or Heart Failure	Yes No	Frequent Indigestion	Yes No
Digitalis Treatment	Yes No	Ulcers	Yes No

Shortness of Breath	Yes	No	
Chest Pain	Yes	No	
Asthma	Yes	No	
Bronchitis	Yes	No	
Pneumonia	Yes	No	
Tuberculosis	Yes	No	
Smokers Cough	Yes	No	
Emphysema	Yes	No	
Coughing or Spitting of Blood	Yes	No	
Hay Fever	Yes	No	
Major Allergies	Yes	No	
Palsy or Paralysis	Yes	No	
Nervous Breakdown	Yes	No	
Nervous Disorder	Yes	No	
Insomnia	Yes	No	
Drug Habit	Yes	No	
Self-Destructive Tendencies	Yes	No	
Psychiatric Hospitalization or Care	Yes	No	
Thyroid Problems	Yes	No	
Kidney or Renal Disease	Yes	No	
Heart murmur	Yes	No	
Piercing other than the ears	Yes	No	
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No	
Missed or irregular last menstrual period	Yes	No	
Family history of cancer, heart trouble, stroke	Yes	No	

Gastritis	Yes	No	
Colitis	Yes	No	
Problem Constipation	Yes	No	
Vomiting Blood	Yes	No	
Tarry or Bloody Bowel Movements	Yes	No	
Hemorrhoids	Yes	No	
Goiter or Thyroid Disorders	Yes	No	
Diabetes	Yes	No	
Skin Disorders	Yes	No	
Arthritis	Yes	No	
Fracture of Neck or Spine	Yes	No	
Bleeding Tendency or Disorder	Yes	No	
Abnormal Bleeding after Tooth Extraction	Yes	No	
Airway Obstruction (Nasal)	Yes	No	
Breast Cysts, Tumors, Abscesses	Yes	No	
Nipple Discharge (Apart from Normal Lactation)	Yes	No	
Kidney Disorder	Yes	No	
Blood Transfusion	Yes	No	
Seizures or convulsions or fainting spells	Yes	No	
Black outs	Yes	No	
Dentures, bridges, capped teeth or crowns	Yes	No	
Loose teeth	Yes	No	
Cosmetic bonding to teeth	Yes	No	
Any family members with bleeding problems	Yes	No	
Any family members with anesthesia problems	Yes	No	

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

_____

1. Do you have an allergy to any medication? Yes No Which? _____
2. Have you ever reacted abnormally to any medication? Yes No Which? _____
3. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?

   Yes No If yes, when and where? _____

4. Have you ever been on cortisone or steroid treatment? ◯ Yes ◯ No When? _____

5. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?

   ◯ Yes ◯ No If so, how much? _____

6. Do you smoke? ◯ Yes ◯ No If so, how much? _____ For how long? _____

7. Are you pregnant? ◯ Yes ◯ No When was your last normal menstrual period? _____

8. How many pregnancies? _____ Births? _____ Breast Fed? ◯ Yes ◯ No How long? _____

   CHILDREN (list names and ages/birthdays): _____

   _____

9. When was your last physical exam? _____ By whom? _____

10. When was your last eye examination? _____ By whom? _____

11. When was your last mammogram? (if applicable to your surgery)
    _____

12. When and where was your last chest x-ray? _____ EKG? _____

13. Who is your personal physician, if any? _____Please list all physicians presently caring for you.

    _____
    _

14. Have you ever been under psychiatric care? ◯ Yes ◯ No When? _____Why? _____

15. Have you had any recent blood work done? ◯ Yes ◯ No Where? _____

16. Is there anything else you think the doctor should know? _____

    _____

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

    SURGICAL OPERATIONS (include where, when and why for each surgery): _____

    _____

    _____

    HOSPITALIZATIONS (include where, when and why for each admission): _____

    _____

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

Signature: _____ Date: _____

bod:evolve

PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

_____ _____

Date Name