KAPIL SAIGAL MD, FACS
FACIAL PLASTIC SURGERY • NOSE & SINUS
BOARD CERTIFIED

PATIENT INTAKE FORM

Patient's Last Name ______________________________ First Name ________________________________ Middle Initial _____

Date of Birth ___________________________ Age _____________ Sex: F M SSN _________________________________

Address ____ Apt.#______ City ____

State _______ Zip ______________ Home Phone ______________________________ Cell Phone _________________________

Business Phone _________________________ E-mail Address ____

Employer _________________________________ Employer Address ____

Medical Doctor Name _____________________________________ Medical Doctor Telephone ______________________________

Medical Doctor Fax____________________ Medical Doctor Address ____

Language _____________________________ Race ___________________________ Ethnicity ____________________________

Emergency Contact ____ Phone # _________________________________

WHAT IS THE MAIN REASON YOU ARE HERE TODAY? ____

Cosmetic Interests (Check all that apply):

□ Botox/Dysport Cosmetic □ Lip Enhancement □ Non-surgical Nose Job
□ Cheek/chin augmentation □ Tear Trough

Facial Surgery Interests (Check all that apply):

□ Neck Liposuction □ Nose □ Facial Implants
□ Facelift □ Eyelid/Eyebrow □ Fat transfer
□ Skin Cancer Reconstruction □ Scar Revision □ Facial cyst/mass

PHARMACY INFORMATION (Include Address &/or Phone)

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I understand that my medication history may be obtained utilizing electronic information exchange and that this protected health information may provide valuable information for my healthcare provider. I hereby authorize Ear, Nose & Throat Associates of New York, P.C. to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal): ☐ **No Current Medications**

List of Medication(s)	Dosage	List of Medication(s)	Dosage	List of Medication(s)	Dosage
1.______________________	______	3.______________________	______	5.______________________	______
2.______________________	______	4.______________________	______	6.______________________	______

ALLERGIES TO MEDICATIONS: ☐ **No Allergies to Medications**

____
____

REVIEW OF SYSTEMS: Please mark where applicable

Blood or Lymph nodes problems

Yes No
☐ ☐ Easy Bleeding
☐ ☐ Easy Bruising

Heart or circulation problems

Yes No
☐ ☐ Blacking Out
☐ ☐ Chest Pain
☐ ☐ Heart Murmur
☐ ☐ Irregular Heartbeat/Palpitations
☐ ☐ Swelling of Ankles/Edema

Nose & Sinus problems

Yes No
☐ ☐ Congestion
☐ ☐ Facial Pain
☐ ☐ Mouth Breathing
☐ ☐ Nose Bleeds
☐ ☐ Post Nasal Drainage
☐ ☐ Runny Nose

Brain or Nervous system problems

Yes No
☐ ☐ Focal Weakness
☐ ☐ Headache
☐ ☐ Numbness
☐ ☐ Seizures

Lung or respiratory problems

Yes No
☐ ☐ Cough
☐ ☐ Shortness of Breath
☐ ☐ Wheezing

Skin

Yes No
☐ ☐ Contact Allergy
☐ ☐ Itchy Skin/ Pruritus
☐ ☐ Rash

Ear problems

Yes No
☐ ☐ Dizziness
☐ ☐ Drainage
☐ ☐ Ear pain
☐ ☐ Exposure to Excessive Noise
☐ ☐ Hearing loss
☐ ☐ Infections
☐ ☐ Itchiness
☐ ☐ Ringing /Noise in Ears

Mouth & Throat problems

Yes No
☐ ☐ Difficulty Swallowing
☐ ☐ Hoarseness
☐ ☐ Sleep Apnea
☐ ☐ Snoring
☐ ☐ Sore Throat
☐ ☐ Sores/Ulcers in Mouth

Stomach problems

Yes No
☐ ☐ Abdominal Pain
☐ ☐ Constipation
☐ ☐ Diarrhea
☐ ☐ Heartburn
☐ ☐ Nausea
☐ ☐ Vomiting/Goiter

Eye problems

Yes No
☐ ☐ Double Vision
☐ ☐ Itchy Eyes
☐ ☐ Redness

General health problems

Yes No
☐ ☐ Fatigue
☐ ☐ Fever
☐ ☐ Night Sweats
☐ ☐ Weight Loss
☐ ☐ Weight Gain

MEDICAL HISTORY: ____ ☐ **No Medical History**

FAMILY HISTORY: ____ ☐ **No Family History**

SMOKING STATUS & SOCIAL HISTORY

Tobacco Use? ☐ Yes ☐ No ☐ Former Amount per day? ______________ Quit Date? ______________
Alcohol Consumption? ☐ Yes ☐ No Type: ____________________ Amount per day? ________________________
Caffeine Consumption? ☐ Yes ☐ No Type: ____________________ Amount per day? ________________________

I have received a copy of Saigal Facial Plastic Surgery notice of privacy practices.

Patient Name: ____ **DOB:**__________________________

Responsible Party Signature: ______________________________________ **Date:** __________________________