Aesthetic Plastic Surgery of Pittsburgh
5750 Centre Ave Pittsburgh PA. 15206
Patient Medical History

CONFIDENTIAL INFORMATION: Information contained herein will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. This information that you provide will be used by your provider in their decision regarding your care.

Patient Information:		
Sex: ◯ M	◯ F	◯ Other
Last Name: ___________	First Name: _____________	Middle: __________________
DOB: ____/_____/________		Age________
Height ______		Weight ________
◯ Married	◯ Widowed	◯ Divorced
Physician Information:		
Referring Physician _________________	Primary Care Physician	
Date of Last Physical Exam: ____		

Medical Information: Do you have or have you had: Circle if yes please give date of occurrence.

Do you have or have you previously had: (circle if yes, date of occurrence)

Aids or HIV No Yes_____ Congenital Heart Disease No Yes_____

Arthritis No Yes_____ Diabetes No Yes____
Asthma No Yes_____ Epilepsy No Yes_____

Back Problems No Yes_____ Goiter No Yes_____
Bladder infection No Yes_____ Seasonal Allergies No Yes_____

Bleeding tendency No Yes_____ Heart Attack No Yes_____

Bronchitis No Yes_____ Hepatitis No Yes_____

Covid-19 No Yes_____ Autoimmune Disease No Yes_____
Cancer No Yes_____ High blood Pressure No Yes_____
Colitis No Yes_____ Kidney Disease No Yes_____
Mental illness No Yes_____ Migraine No Yes_____
Nervous Breakdown No Yes_____ Pneumonia No Yes_____
Rheumatic Heart No Yes_____ Stomach ulcers No Yes_____
Stroke No Yes_____ Tonsillitis No Yes_____

Food Allergies No Yes_____

Date of last chest x- ray_____________________

Other serious illnesses that you have had: ___________________________________

Do you smoke? No Yes_____ How much? ___________

Previously smoked: How many years: ____ Quit Date: _______________

Do you smoke marijuana? No Yes_____ How much? ___________

Previously smoked marijuana: How many years: ____ Quit Date: _______________

Do you drink alcohol or beer? No Yes_____How much? _________________

Are you presently taking any of the following medications? (circle)

Antibiotics
Aspirin, Bufferin, Anacin
Barbiturates
Birth control pills
Blood pressure pills
Blood thinning – pills
Cortisone
Cough Medicine
Digitalis

Dilantin
Headache pills
Hormones
Insulin or diabetic pills
Laxatives
Medicine for arthritis
Phenobarbital
Allergy Shots
Sleeping pills

Thyroid medicine
Tranquilizers
Water pills
Weight reducing pills
Other drugs not listed.
____

Why are you here today?

___

___

___

Do you know of any blood relative who has or had? (circle and list relationship)

Arthritis _____

Asthma ______

Bleeding tendency ______

Breast cancer _____

Other cancer______

Colitis_______

Congenital heart disease _____

Diabetes ______

Kidney Disease _______
Leukemia _______

Mental illness

Migraine______

Mental illness_______

Rheumatic Heart ______

Epilepsy _____

Goiter______

Hay fever______

Heart attack _______

High blood pressure _______

High fever after surgery______

Stomach ulcers_______

Stroke______

Suicide _____

Tuberculosis________

Medical Information continued:

Please list any medications or over the counter that you have taken with in the last 3 months

___

___

___

Please list the names and year of any operations you have ever had:

___

___

___

Please name any drugs to which you are allergic:

Have you ever had any complications from anesthesia Yes ____ No _____?

Explain

Woman:

Is there any chance you may be pregnant No Yes?

Are you still having regular monthly menstrual periods? No Yes Date of last menstrual cycle________

Dare of last mammogram _________

How many children? _______

Provider comments:

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PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

- I consent to the taking of photographs by Dr. Marc D. Liang or his designee of me or parts of my body in connection with the plastic surgical procedure(s) to be performed by Dr. Marc D. Liang.
- I understand that such photographs may be used for:

If you choose to grant consent for release of photographs, INITIAL each of those you will approve release for:

Personal Viewing (Patient, Physician and Nurse Only)
Before and After Photo Book in Dr. Liang's consultation room
Seminars given by Marc D. Liang, M.D., F.A.C.S.
Medical publications/representation
Print, visual and electronic media i.e Instagram, Facebook
Website

- Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features, which shall make my identity recognizable.
- I release and discharge Aesthetic Plastic Surgery of Pittsburgh and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for prepayment in connection with distribution or publication of the photographs.
- I **grant** this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.
- I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Aesthetic Plastic Surgery of Pittsburgh.
- I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below.
- I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

Patient Signature Date

____

Print Name

WITNESS/PHYSICIAN:

GUARDIAN

I have read the above Authorization and Release. I am the parent, guardian or conservator of the minor, ____. I am authorized to sign this consent on his/her behalf and I grant this consent as voluntary contribution in the interest of public relation.

Print Name