

Name: <small>(Print Clearly)</small>		Today's Date:	
D.O.B.	Height:	Weight:	Current Bra Size:

Breast History

1. Have you ever had a mass in your breast or discharge from the nipple? _____
2. Have you had a breast biopsy? _____ When? _____ Result: _____
3. Is there any breast cancer in your family? _____ Relationship: _____
4. Have you had a mammogram (x-ray of the breast)? _____ When? _____
5. Do you feel that your breast are equal in size and shape? _____
6. If you have children, do you plan to nurse? _____
7. How many pregnancies have you had? _____
8. Do you plan to have any more children? _____
9. Date of your last menstrual cycle: _____

COMPLETE IF YOU ARE USING INSURANCE FOR A BREAST REDUCTION

Insurance Company:	Member ID #:
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Your insurance company has strict guidelines that must be met in order for your procedure to be covered. Please answer the following questions in order to facilitate the authorization process.

Mark the persistent symptoms that have affected your daily activities for at least 1 year:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Pain in Upper Back | <input type="checkbox"/> Painful Kyphosis | <input type="checkbox"/> Skin Irritation | <input type="checkbox"/> Shoulder Groves |
| <input type="checkbox"/> Pain in Neck | <input type="checkbox"/> Headaches | <input type="checkbox"/> Breast Pain | <input type="checkbox"/> Slouching |
| <input type="checkbox"/> Pain in Shoulders | <input type="checkbox"/> Pain / discomfort / ulceration from bra straps cutting into shoulders | | |
| <input type="checkbox"/> Other: _____ | | | |

Have you tried any of the following (for at least 3 months) to relieve the symptoms and have had little to no improvement?

- | | | |
|--|-----------------------------------|--|
| <input type="checkbox"/> Chiropractic Care | <input type="checkbox"/> Exercise | <input type="checkbox"/> Special supportive Bras |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Massage | <input type="checkbox"/> Medication: _____ |
| <input type="checkbox"/> Other: _____ | | |

Patient Signature: _____ **Date:** _____

OFFICE USE ONLY - LETTER OF MEDICAL NECESSITY

CPT CODES: o 19318 -Reduction Mammoplasty o 19318.5 -Reduction Mammoplasty 2 nd side o _____	BMI	APPR. GMS OF TISSUE TO BE REMOVED: Right Side _____ gms Left Side _____ gms
	ICD-9 CODES: o 611.1 o 611.71 o 611.8 o 695.89 o _____ o 723.1 o 724.5 o 781.9 o _____ o _____	FACILITY o Outpatient o Inpatient (# of Days: _____) o Thousand Oaks Surgical Hospital (77-0521861) o Los Robles Surgical Center (77-0216847) o Los Robles Hospital (95-2321136) o Other: _____

Doctor's Signature: _____ **Date:** _____

Anatomical Data Sheet

Name: _____ Date: _____

Face & Eyelid

1. Have you ever had facial palsy? _____
2. Have you ever had tumors or cysts excised from your face? _____
3. Have you ever had a fracture of your facial bones or neck? _____
4. Have you had recent dental work? _____ Do you wear dentures? _____
5. Do you wear glasses or contact lenses? _____
6. Do you have or had glaucoma? _____
7. Have you ever had double vision? _____
8. Do your eyes tend to tear or feel irritated? _____
9. Do you use any medication in your eyes? _____
10. When was your last examination by an ophthalmologist? _____
11. Have you had previous facial cosmetic surgery? _____
 When? _____ Where? _____ What? _____

Nose

1. Have you ever had an injury to your nose? _____ When? _____
 How? _____ Treatment? _____
2. Have you had any previous surgery on your nose or septum? _____
3. Do you have any difficulty breathing through your nose? _____
4. Do you have allergic problems, sinusitis or headaches? _____
5. Do you take frequent nose drops and/or sprays? _____
6. Do you experience frequent nosebleeds? _____
7. Do you have pain in your nose? _____

Abdominal Wall

1. List all previous surgery involving your abdomen? _____

2. Have you ever had a hernia? _____ Repaired? _____
3. How many pregnancies have you had? _____
4. Do you plan to have any more children? _____
5. Have you gained or lost a large amount of weight recently? _____
6. What is your present weight? _____
7. What do you consider your best or optimum weight? _____
8. Date of your last menstrual cycle? _____

NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ WEIGHT: _____ HEIGHT: _____

PRIMARY CARE PHYSICIAN: _____ INSURANCE: _____

REASON FOR YOUR APPOINTMENT: _____

GENERAL HISTORY:

- How would you describe your health? Excellent Good Fair Poor
- Have you had or do you have any problems with the following? Check the box for Yes
 Thyroid Bladder Kidneys Nerves Pancreas Skin Heart
 Lungs Stomach Liver Intestines Gallbladder Bones Other
If yes, describe the problem: _____
- Are you taking any Blood Pressure Medications? **Yes / No** List: _____
- Do you have, or have you had Cancer? **Yes / No** Where? _____ When? _____ Treatment: _____
- Are you a Diabetic? **Yes / No** Medication: _____
- Do you bruise or tend to bleed easily? **Yes / No** Do you tend to form large scars or keloids? **Yes / No** _____
- List all previous surgeries: _____

- What was the date of your last physical exam by a physician? _____ EKG? _____ Chest X-ray? _____
- Have you had any Psychiatric Treatment? _____
- Do you Smoke? **Yes / No** Amount/per day: _____ Do you Drink Alcohol? **Yes / No** Amount/per day: _____
- Have you had a recent Weight Loss? **Yes / No** Weight Gain? **Yes / No** Explanation? _____
- Do you have a history of Phlebitis or Varicose Veins? **Yes / No**
- Have you ever been immunized for Hepatitis B? **Yes / No** Have you ever been diagnosed with Hepatitis C? **Yes / No**

MEDICATION HISTORY:

- Are you allergic to any medications or materials? **Yes / No** Please list: _____
- What medications are you presently taking? _____

- Have you ever had a reaction to Local Anesthetics? _____ List & describe the reaction: _____
- Have you had a problem with nausea with anesthesia? _____
- Do you have Mitral Valve Prolapse? **Yes / No**
- Have you ever taken Phen-Fen **Yes / No** When? _____ How Long: _____
- Do you take any of the following? Check the box for Yes

Your honesty in answering the following questions is extremely important.
If you answer yes, please state the frequency and last time you took the medication.

Over the Counter Remedies

- Aspirin
- Aspirin Compounds
- Ibuprofen (Motrin, Advil, Datriil)
- Acetaminophen (Tylenol)
- Naproxen Sodium (Aleve)

Diet Aids

- Redux
- Dexatrim
- Meridian
- The Formula
- Herbal/Weight loss products

Herbal / Natural Remedies

- St. John's Wort
- Echinacea
- Goldenseal
- Ma Huang (Ephedra)
- Airborne

Vitamins

- Niacin
- Vitamin E
- Vitamin B
- Vitamin C
- Calcium
- Potassium

Do you presently use or have you ever taken any recreational/"street" drugs? **Yes / No**

If yes, please specify: (example: Marijuana, cocaine, "speed") _____

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PATIENT INFORMATION: (PLEASE PRINT CLEARLY):

NAME (LAST, FIRST, M.I.):		DATE OF BIRTH:	AGE:	GENDER: MALE FEMALE		SOCIAL SECURITY #
STREET ADDRESS:		CITY, STATE		ZIP CODE	HOME TELEPHONE # ()	
Email Address:		CITY, STATE		ZIP CODE	BUSINESS TELEPHONE # () EXT:	
MARITAL STATUS: __SINGLE __MARRIED __WIDOWED __DIVORCED __LEGALLY SEPARATED		EMPLOYMENT STATUS: __FULL TIME __PART TIME __UNEMPLOYED __RETIRED				CELLULAR TELEPHONE # ()
REFERRED TO OFFICE BY:		PATIENT'S OCCUPATION:				HOW LONG EMPLOYED:

RESPONSIBLE PARTY: (IF DIFFERENT THAN ABOVE)

NAME (LAST, FIRST M.I.):		DATE OF BIRTH:	GENDER MALE FEMALE		SOCIAL SECURITY #
STREET ADDRESS:		CITY, STATE		ZIP CODE	HOME TELEPHONE # ()
EMPLOYER:	STREET ADDRESS:	CITY, STATE		ZIP CODE	BUSINESS TELEPHONE # () EXT:

INSURANCE INFORMATION: (Complete in Addition to Card Copies on File)

PRIMARY INSURANCE:	ID#	GROUP#	OFFICE VISIT COPAY:
NAME OF INSURED:	SOCIAL SECURITY #	DATE OF BIRTH:	RELATIONSHIP TO PATIENT:

SECONDARY INSURANCE:	ID#	GROUP#	
NAME OF INSURED:	SOCIAL SECURITY #	DATE OF BIRTH:	RELATIONSHIP TO PATIENT:

CLAIMS INFORMATION:

ACCIDENT: YES NO	EMPLOYMENT RELATED: YES NO	AUTO RELATED: YES NO	DATE OF INJURY:
WORK COMP CARRIER:	ADJUSTOR:	ADJUSTOR TELEPHONE # EXT:	ADJUSTOR FAX #
REFERRING PHYSICIAN:	STREET ADDRESS:	CITY, STATE	ZIP CODE TELEPHONE # ()