BESANA
HEALTH & WELLNESS

Atagi Plastic Surgery and
Atagi Skin Aesthetics

Legal Name**:** _____Nickname: _____ Today's Date: _____

Date of birth:
_____ Age: _____ What is your current gender identity? (Check ALL that apply):

☐ Male ☐ Female ☐ Transgender Male/Transman/FTM ☐ Transgender Female/Transwoman/MTF ☐ Gender Queer

☐ Additional category (please specify): _____ What sex were you assigned at birth? (Check one) ☐ Male ☐ Female

E-mail: _____ Cell Phone: _____ Ok to leave a Message? y/n
Text appointment reminders? y/n

Street Address: _____City: _____State:_____ Zip:_____

Occupation: _____ Employer: _____

How did you hear about us? _____

Primary Care Physician: _____Phone: _____

_____***Initials*** I am giving you permission to email me your e-newsletter. **Privacy Policy:** We respect your privacy and will not share your information. Our e-newsletter contains a one click unsubscribe, so you may leave our list anytime.

_____***Initials*** **Email/ Text Communication Consent:** Communication via text messages, will not be encrypted; however, the phones being used by employees are password protected. Please note that email/text communications should never be used for emergency communications. Email/ text communication will not be used to communicate highly sensitive medical information. All correspondence will be added to your medical record. You are responsible for taking steps to protect yourself from unauthorized use of communications, such as keeping your password confidential. Atagi Aesthetics and Besana Wellness is not responsible for breaches of confidentiality caused by you or an independent third party.

_____***Initials*** **Telemedicine Services Informed Consent:** Telemedicine is healthcare provided by means other than face-to-face visits. Telemedicine utilizes the use of electronic communications such as telephone consultation, video conferencing, patient portals and e-health technology, for diagnosis, consultation, treatment, therapy, follow-up, and education. The laws that protect privacy and confidentiality of medical information also apply to telemedicine, and no information obtained in the use of telemedicine will be disclosed without my consent. I understand that telemedicine involves electronic communication of my personal medical information to other practitioners who may be involved in my care. I understand that telemedicine billing information will be collected in the same manner as a regular in-office visit. I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communication by others.

_____ ***Initials*** I understand that payment is due in full at the time of service. I also understand that if I would like insurance reimbursement, it is my responsibility to submit a claim. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre-certify, medical record submission, or answer letters of appeal.

_____ ***Initials*** I acknowledge that I have read and had the opportunity to receive a copy of The Notice of Privacy Practices for Protected Health Information ("The Notice") for the practice of Atagi Aesthetics and Besana Wellness.

I ***authorize you to disclose*** my Protected Health Information to the following individual for billing, scheduling appointments, and treatments:

Emergency Contact Name: _____ Phone: _____ Relationship: _____

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NAME: _____

GENERAL: Specific reason(s) for which you are being seen or concerns (check any that may apply):

Aesthetic Surgery

- ☐ Face/ Neck
- ☐ Eyes/ Brows
- ☐ Lips
- ☐ Ears
- ☐ Scars
- ☐ Small Breasts
- ☐ Large Breasts
- ☐ Sagging Breasts
- ☐ Liposuction
- ☐ Tummy Tuck

Non- Surgical Services

- ☐ Skincare / Product information
- ☐ Facials
- ☐ Dermaplane/ Microdermabrasion
- ☐ Chemical Peels
- ☐ Laser Treatments
- ☐ Botox/ Xeomin/ Dysport
- ☐ Dermal Fillers
- ☐ Exilis/ Vanquish
- ☐ Ultherapy
- ☐ Novathreads

Wellness

- ☐ Bio-Identical Hormones
- ☐ Functional Medicine
- ☐ Reiki
- ☐ Clinical Nutrition
- ☐ Thyroid Management
- ☐ Chiropractic
- ☐ Massage

Other: _____

MEDICAL HISTORY:

Have you ever had or do you have any of the following (please check and/or circle)

- ☐ Active Infection
- ☐ Anemia
- ☐ Arrhythmia
- ☐ Arthritis: Type: _____
- ☐ Bleeding Disorders / Easy Bruising
- ☐ Blistering Sunburns
- ☐ Blood Clots
- ☐ **Breast Cancer**
- ☐ Cancer: Type(s) _____
- ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- ☐ Circulation Problems
- ☐ Cold Sores / Shingles: Location: _____
- ☐ Depression / Anxiety
- ☐ Diabetes: Type _____
- ☐ Eye Problems / Dry eyes / Glaucoma
- ☐ Glasses / Contact Lens: Both Right Left
- ☐ Endocrine / Immune Problems _____
- ☐ **Fibrocystic Breast Disease**
- ☐ Fibromyalgia
- ☐ Fatigue
- ☐ Gastrointestinal Problems / Ulcer / Hernia / Reflux / IB
- ☐ Genitourinary / Kidney stones / Menstrual
- ☐ **Hashimoto's thyroiditis**
- ☐ Headaches / Migraines
- ☐ Heart attack/ Bypass/Heart Condition:_____
- ☐ Hepatitis: Type _____
- ☐ Hernia
- ☐ High Blood Pressure / Low Blood Pressure
- ☐ High cholesterol
- ☐ HIV / AIDS
- ☐ Hormonal Imbalance / Hormonal Issues
- ☐ Insomnia / Sleeping Problems
- ☐ Joint Injuries
- ☐ Metal Implants: Location(s): _____
- ☐ Multiple Sclerosis
- ☐ Muscle Pain / Spasms / Numbness / Tingling
- ☐ **Leiomyoma or Endometrial Polyps.**
- ☐ Neurological Disorder: Type: _____
- ☐ Ovarian Cancer
- ☐ Pacemaker / Defibrillator
- ☐ Permanent Makeup / Tattoo(s): Location(s): _____
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Melanoma / Other Skin Cancer: Location(s): _____
- ☐ **PCOS**
- ☐ Psychiatric Disorder
- ☐ Pulmonary emboli
- ☐ Respiratory Problems / Asthma / Pneumonia / COPD
- ☐ Scleroderma / Lupus /Autoimmune Disorder: Type: _____
- ☐ Sensitive Teeth
- ☐ Seizures: Last episode: _____
- ☐ Sinus problems / Sinusitis / Difficulty breathing
- ☐ Skin Conditions /Acne / Eczema / Psoriasis / Other: _____
- ☐ Stroke
- ☐ Thyroid Problems: Type: _____
- ☐ Trouble passing urine or take Flomax or Avodart
- ☐ Unusual Moles: Location(s): _____
- ☐ Uterine Cancer
- ☐ Varicose Veins
- ☐ Other:

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NAME: _____

What is your present: Height: _____Weight:_____

Women Only

Could you be pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Date of last menstrual period? _____

Birth Control Method: ☐ **Menopause** ☐ **Tubal Ligation** ☐ **Birth Control Pills** ☐ **Vasectomy** ☐ **Other** _____
☐ **Hysterectomy with removal of ovaries.** ☐ **Hysterectomy, uterus only.** ☐ **Oophorectomy, removal of ovaries.**

Preventative Care: ☐ **Medical/ GYN exam within the last 12 months.** ☐ **Mammogram within the last 12 months.** ☐
Bone Density test within the last 12 months. ☐ **Pelvic ultrasound within the last 12 months.**

OB/GYN: _____ Phone: _____

SURGICAL HISTORY: Please list **ALL** prior surgical procedures. (This includes minor procedures: tooth extractions/tonsils/appendix/gallbladder, LASIK, etc.)

Year	**Procedure**	**Surgeon**	**Complications**

MEDICATIONS: - Please list **ALL** medications including **herbs, dietary supplements, or weight reduction** products.

Medication	Dose	Why?	Medication	Dose	Why?

Do you take aspirin or ibuprofen products? ☐**Yes** ☐**No**

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

SOCIAL HISTORY:

☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed Children Age(s):_____

Do you smoke? Or have you ever smoked? ☐**Yes** ☐**No**
If yes, indicate appropriate reply:
_____Cig's or Packs / Day_____ x Years Quit _____ weeks/months/years ago

Do you drink alcohol? ____ times/Day ____ times/Week ____ Rarely _____ Never

Do you drink caffeinated beverages? ☐**Yes** ☐**No** If yes:_____/Day

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NAME: _____

ALLERGIES & SENSITIVITIES: Latex Allergies? ☐**Yes** ☐**No** Environmental or Food Allergies? ☐**Yes** ☐**No** Medication Allergies or Sensitivities? ☐**Yes** ☐**No** Tape or Adhesive Sensitivities? ☐**Yes** ☐**No** **Type?** _____ If so, please indicate drug and circle reaction(s).

	Medication(s)	**Reaction**
_____	Rash/Hives/Anaphylaxis/Swelling/Nausea/Vomiting/Other	_____
_____	Rash/Hives/Anaphylaxis/Swelling/Nausea/Vomiting/Other	_____

ANESTHESIA HISTORY:

- ☐ None
- ☐ General Anesthesia: Nausea/Vomiting/Slow awakening/Difficult intubation/other _____
- ☐ IV Sedation: Nausea/Vomiting/Slow awakening/other _____
- ☐ Epidural/Spinal: Nausea/Vomiting/Insufficient/Bleeding/Headache/Other _____
- ☐ Block: Insufficient /Prolonged/Systemic reaction/other _____
- ☐ Local: Insufficient block/Heart palpitations/Systemic reaction/other _____

FAMILY HISTORY: Do you have a family history of:

			Relationship	Problem
Heart problems	☐**Yes**	☐**No**		
Diabetes	☐**Yes**	☐**No**		
Breast cancer	☐**Yes**	☐**No**		
Other cancers	☐**Yes**	☐**No**		
Thyroid	☐**Yes**	☐**No**		
Stroke	☐**Yes**	☐**No**		
Bleeding problems	☐**Yes**	☐**No**		
Anesthesia problems	☐**Yes**	☐**No**		
Other problems	☐**Yes**	☐**No**		

SKINCARE:

Please indicate your current skincare routine and products: _____
Please list any products or treatments that irritate your skin: _____
Have you had any of the following facial procedure performed?

Facial/ Oxygen Facial ☐**Yes** ☐**No** Chemical/ Enzyme Peel ☐**Yes** ☐**No**
Laser treatments ☐**Yes** ☐**No** Dermaplane/ Microdermabrasion ☐**Yes** ☐**No**
Have you ever used Accutane? ☐**Yes** ☐**No** Would you like a color match with our make-up? ☐**Yes** ☐**No**

Patient Signature: _____ Date: _____

Atagi Aesthetics representative: _____ Date: _____

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303.327.7300 | BesanaWellness.com
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Name: _____ **Date:** _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Anxiety/ nervousness (inner restlessness/ tension, feeling panicky, fidgety)				
Bloating or abdominal pain after eating				
Cold hands and feet				
Decline in your feeling of general well-being (general state of health, subjective feeling)				
Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)				
Excessive sweating (sudden/ unexpected episodes of sweating, hot flushes independent of strain)				
Feeling burnt out, having hit rock-bottom				
Hair Loss (beard, scalp, body)				
Heart discomfort (unusual awareness of heartbeat, heart skipping, heart racing, tightness)				
Irritability (feeling nervous, inner tension, feeling aggressive)				
Joint pain and muscular ache (pain in the joints, rheumatoid complaints)				
Mental exhaustion (impaired memory, decrease in concentration, forgetfulness)				
Physical exhaustion / lacking vitality (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of having to force oneself to undertake activities)				
Sexual problems (change in sexual desire, in sexual activity and satisfaction, decrease in ability/ frequency to perform sexually)				
Sleep problems (difficulty in falling asleep, difficulty in sleeping through the night, waking up early and feeling tired, poor sleep, sleeplessness)				
Unexplained weight loss/ gain				

Women Only

Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence)				
Hot flashes				
Vaginal dryness (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)				

Men Only

Decrease in muscular strength (feeling of weakness)				
Decreased morning erections				
Decrease in beard growth				
Feeling you have passed your peak				

Other symptoms that concern you:

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