Aimee Nguyen, M.D. Cosmetic Vaginal Surgery

PATIENT INFORMATION SHEET

Name:
First_____Middle_____Last_____

Address_____

City_____ State_____ Zip Code_____-_____

Home Phone# (____) _____-_____ Work# (____) _____-_____ Cell# (____) _____-_____

Emergency# (___) ____-_____ Emergency Contact Name _____ _____ Relationship _____

Social Security Number ____-_____-_____ Date of Birth____/_____/_____ Age: ____ Male Female

E-mail Address_____ @_____ Marital Status S M D W

Ethnicity:_____ Language: _____

Who is your primary care physician? _____Phone: (____) _____-_____
(If you go to a group please specify the name of the physician you see most often.)

Preferred Pharmacy Name_____ Address/Phone Number_____

Employer Name & Address: _____City & State_____

_____

INSURANCE INFORMATION

Name of Primary Insurance Company _____Policy #_____Group #_____

Name of Secondary Insurance Company _____Policy #_____Group #_____

POLICY HOLDER INFORMATION (If Other Than Patient)

Name: _____ Relationship to Patient _____ Date of Birth ___/___/___

Social Security Number: ____-____-____ Address: (if different from patient) _____

Employer Name, Address, & Phone _____ (____) ____-_____

Release of Information Authorization

Please mark below for release of information concerning your healthcare and/or financial arrangements:

Release information ONLY to me: ___ Yes ____ No
Release of Information to Spouse: ___ Yes ____ No
Spouse's Name: _____

Release of Information to Other Individual: ___ Yes ____ No
Name & Relationship: _____
Phone #: _____

Preferences

I prefer to be contacted in the following manner:

Phone#: ( ) _____

- ☐ Leave message with detailed information.
- ☐ Leave message with contact number only.
- ☐ Do not leave message.

I am fully aware my health information will be transmitted by electronic transmission, fax transmittal, internet or e-mail.

Signature _____ _____
Patient/Guardian Date

Authorization to Release Information: I authorize Aimee Nguyen, M.D. to release any information necessary, acquired in the course of my treatment, to process insurance claims. **Initial Here _____**

Authorization to Pay Benefits Directly: I authorize the payment of all benefits to Aimee Nguyen, M.D. directly for medical service rendered. **Initial Here _____**

Signature _____ **Date ____/____/____**

Consent to receive text messages about appointment reminders: Patients in our practice

I _____ consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number to receive appointment reminders. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing.

- The **CELL PHONE NUMBER** that I authorize to receive
  - TEXT Reminders
    - Is: (_____) _____-_____

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details

Aimee Nguyen, M.D.
Dr Rejuvenation

Name: _____Age:_____Date: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

____A Physician Name: _____ Phone: _____
____Family Member/Friend Name: _____
____Newspaper/Television Which publication/program _____
____Internet Website: _____
____Other Please explain_____

Are you currently under the care of or have you ever been treated by a Medical Physician for any significant illness other than colds, flu or virus? If so, please explain:

_____

Current Height _____ Current Weight _____

Do you have any of the following conditions:			If YES, please explain?
Cardiac History	No	Yes	_____
Diabetes	No	Yes	_____
Asthma	No	Yes	_____
Hepatitis	No	Yes	_____
Sleep Apnea	No	Yes	_____
Bleeding Problems	No	Yes	_____
Hypertension	No	Yes	_____
HIV/AIDS	No	Yes	_____

Other (please explain): _____

Are there any significant illnesses or cancer that runs in your family? Please provide details:
_____
_____

Have you had any surgical procedures in the past?

Date (mm/yy)	Type of Surgery	Date (mm/yy)	Type of Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Number of pregnancies _____ Number of Children _____ Vaginal delivery/C-section

SOCIAL HISTORY

Alcohol Use: Never _____ Occasional _____ Drinks per week _____
Are you a: current smoker ☐ former smoker ☐ non- smoker ☐
If yes... how many packs per day _____ how many years _____
Do you use recreational drugs? Y N

CURRENT MEDICATIONS
(Include herbs, vitamins & any other over-the-counter medications.)

Aspirin	Yes	No
Oral Contraceptives	Yes	No
Blood Thinners	Yes	No

Name of Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies to Medications?

Penicillin	Yes	No	if YES, please specify: _____
Local Anesthesia	Yes	No	if YES, please specify: _____
General Anesthesia	Yes	No	if YES, please specify: _____
Any others	Yes	No	if YES, please specify: _____

Do you have any allergies to creams, tape, latex etc.? Yes No

Do you have any bleeding tendencies? Yes No

Symptoms Review: Please circle any symptoms you've had in the past few months:

General Symptoms	**Hematologic/Allergy**	**Gastrointestinal**	**Cardiovascular**
Fever/Chills	Clotting Problems	Abdominal pain	Chest pain
Change in appetite	Swollen Glands	Diarrhea	Chest palpitations
Headache	Hay fever	Blood in stools	Shortness of breath
Wt loss/gain>10 lbs	Prolonged bleeding	Bloating	Swelling of legs
Nausea /vomiting	Easy bruising	Constipation	Palpitations

Neurological	**Endocrine**	**Musculoskeletal**	**ENT**
Memory loss	Excessive thirst	Joint pain	Cold
Dizzy spells	Intolerance to hot/cold	Back pain	Sore throat
Numbness	Excessive fatigue	Weakness	Hearing loss
Insomnia			History of Glaucoma
Tremors			
Loss of balance			

Skin	**Respiratory**	**Gynecologic**	**Psychiatric**
Skin Rash	Wheezing	Breast pain or lump	Depressive symptoms
Boils	Frequent cough	Hot flashes	Thoughts of suicide
Change in -	Cough up blood	Vaginal Bleeding	Anxiety
Appearance of mole	Trouble breathing	vaginal discharge	High Stress level

DR. REJUVENATION

AIMEE NGUYEN M.D.

For Vaginal Rejuvenation

1. Do you notice decreased sensation and stimulation during intercourse?
2. Does your vagina feel loose with minimal muscle tone?
3. Is there tissue protruding from your vagina?
4. Do you have a gaping, widened vaginal opening?
5. Does your partner slip out during intercourse?
6. Do tampons fall out?
7. Does your vagina produce "gas-like" sounds during intercourse or "popping" sounds with walking?
8. Do you leak urine with coughing, sneezing, laughing or exercise?
9. Are you sexually active? Yes / No Do you experience any pain with intercourse? Yes / No Does it take longer to orgasm because of vaginal looseness?

For Labiaplasty

1. Are you dissatisfied with the appearance of your labia due to length, pigmentation, size, or asymmetry?
2. Does your labia interfere with activities like intercourse, cycling, horseback riding or tampon placement?
3. Do the clothes you want to wear make you uncomfortable, or do you find yourself constantly needing to "re-adjust" your labia?
4. Do you notice a bulge or "camel toe" in certain clothes such as bathing suits or jeans?

In addition to the above, (If applicable: Please list the top 2 problems on your "Hit List" that you would like to see improved after surgery

Breast	**Body**	**Face**
1. _____	1. _____	1._____
2. _____	2. _____	2. _____

Are you interested in?

- **Skin Fillers**
- **Botox**
- **Non-Invasive fat reduction**
- **Skin tightening**
- **Cellulite reduction**

DR. REJUVENATION

AIMEE NGUYEN M.D.

Permission to Use Photograph/Video

I, _____, give my informed and voluntary consent to North Dallas Urogynecology and/or her associates to take photographs and/or video of me pre-operatively, intra-operatively, and post-operatively. I understand that these photographs and/or videos will be utilized and posted on social media, advertising, and web content to show the transformation process to the general public which includes current and prospective patients. All pictures will remain anonymous and any identifying features will be blurred out as best as possible, however, I also understand that in some rare circumstances the photographs and/or videos may display features that identify me.

I understand entirely that this authorization is completely voluntary. I understand that any disclosure of information has the potential of unauthorized disclosure and the information may not be protected by applicable federal and/or state confidentiality rules. Dr. Aimee Nguyen or a representative cannot guarantee, nor have liability should you disclose any identifying factors to a third party as they may not be required to maintain your privacy.

By signing this consent, I hereby, knowingly and voluntarily authorize Aimee Nguyen, M.D., to use my photograph(s) and videos in the manner described above.

Signature _____

Printed name _____

Date _____

Signature, parent or guardian _____
(If under age 18)

Witness: _____