

## LIFESTYLE QUESTIONNAIRE - FEMALE

### Gynecological History

1. What is your height? \_\_\_\_\_ Current weight? \_\_\_\_\_ Date of your last period? \_\_\_\_\_
2. Have you had a hysterectomy and oophrectomy?  No  Yes, if yes please describe (why and how old were you?)  
\_\_\_\_\_
3. Have you had an oophrectomy?  No  Yes, if yes please describe (why and how old were you?)  
\_\_\_\_\_
4. Have you tried any supplements or medications to help with your symptoms?  No  Yes If yes, please describe (when, what you used and did it help?)  
\_\_\_\_\_
5. Do you have a **personal** history of breast, uterine, colon or ovarian cancer?  No  Yes If yes, please describe (age, type, treatments):  
\_\_\_\_\_
6. Do you have a **family** history of breast, ovarian, uterine or colon cancer ?  No  Yes If yes, please describe (relation, age, type):  
\_\_\_\_\_
7. When was your last mammogram? \_\_\_\_\_
8. When was your last pap smear? \_\_\_\_\_
9. When was your last colonoscopy? \_\_\_\_\_
10. Do you have mammograms annually?  No  Yes  N/A
11. When was your last dexa scan? \_\_\_\_\_
12. Do you have a primary care doctor you see regularly?  No  Yes
13. Do you have hot flashes or night sweats?  No  Yes If yes, please describe: \_\_\_\_\_
14. Are you currently depressed or being treated for depression?  No  Yes If yes, please describe treatments: \_\_\_\_\_
15. Have you noticed in change in your skin and hair?  No  Yes If yes, please describe: \_\_\_\_\_
16. Have you struggled to keep weight off?  No  Yes
17. Have you noticed a change in fat distribution?  No  Yes
18. Do you find it more challenging to maintain muscle tone?  No  Yes
19. My birth control method is:

<input type="checkbox"/> Abstinence	<input type="checkbox"/> Birth Control Pill
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> IUD
<input type="checkbox"/> Menopause	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Vasectomy	<input type="checkbox"/> Other: _____

**Patient Signature:**

**Date:**

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920-358-1810  
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Name: <PersonallInfo.FullName>  
DOB: <PersonallInfo.DOB>

## Checklist Before FEMALE BHRT Treatment

Place an "X" for EACH symptom you are currently experiencing. Mark only ONE box. Mark NONE for symptoms that do not apply.

	None 1	Mild 2	Moderate 3	Severe 4	Very Severe 5
1. <b>Hot flashes, sweating</b> (episodes of sweating)	<input type="checkbox"/>				
2. <b>Heart discomfort</b> (unusual awareness of heart beat, heart skipping, heart racing, tightness)	<input type="checkbox"/>				
3. <b>Sleep problems</b> (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	<input type="checkbox"/>				
4. <b>Depressive mood</b> (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	<input type="checkbox"/>				
5. <b>Irritability</b> (feeling nervous, inner tension, feeling aggressive)	<input type="checkbox"/>				
6. <b>Anxiety</b> (inner restlessness, feeling panicky)	<input type="checkbox"/>				
7. <b>Physical and mental exhaustion</b> (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	<input type="checkbox"/>				
8. <b>Sexual problems</b> (change in sexual desire, in sexual activity and satisfaction)	<input type="checkbox"/>				
9. <b>Bladder problems</b> (difficulty in urinating, increased need to urinate, bladder incontinence)	<input type="checkbox"/>				
10. <b>Dryness of vagina</b> (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	<input type="checkbox"/>				
11. <b>Joint and muscular discomfort</b> (pain in the joints, rheumatoid complaints)	<input type="checkbox"/>				

Please share any additional comments about your symptoms you would like to address.

Do you have cold hands and feet?  Yes  No

Do you have daily bowel movements?  Yes  No

Do you have gas, bloating or abdominal pain after eating?  Yes  No

Please select your WEEKLY Activity Level based on this criteria ➔ Physical activity that accelerates heart rate / Breathlessness

0-1 day per week (Low)  2-3 days per week (Average)  More than 3 days per week (High)

Please list any prior hormone therapy?

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Name: \_\_\_\_\_  
DOB: \_\_\_\_\_

### Demographics ~ <Appointment.Date>

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Former Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Cell Carrier: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
DOB & Age: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity:  Hispanic  Non-Hispanic  
Sex: \_\_\_\_\_ SSN: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Who is your primary care physician? \_\_\_\_\_  
Preferred Pharmacy (name & location): \_\_\_\_\_  
How did you hear about our practice?  
 Patient: \_\_\_\_\_  Dr. Referral: \_\_\_\_\_  
 Friend: \_\_\_\_\_ First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Other: \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### HIPAA Notice of Privacy Practices

I have been given the opportunity to read, review, obtain a hard copy and ask questions about Fox Valley Plastic Surgery's **HIPAA Notice of Privacy Practices**, and how Fox Valley Plastic Surgery uses and discloses my information and my rights concerning my information. I consent and acknowledge my agreement to the terms set forth in the HIPAA information form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## Consent to Communicate including Transmission of Protected Health Information by Non Secure Means (Email & Text Message)

In order to secure your Protected Health Information (PHI), it is always best to personally go to the office and talk to a representative of Fox Valley Plastic Surgery (FVPS). If this is not possible, the next best methods are to communicate by phone, fax, or U.S. mail. All these methods are secure means of transmitting PHI.

In spite of these secure options, it sometimes may become useful for during the course of treatment for the patient to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with FVPS, there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

FVPS has found that some patients prefer to message or email the office with photos or questions. These are not secure avenues of communication. If you wish the office to respond in kind to your inquiries, you must expressly give FVPS permission to communicate with you with these insecure methods instead of phoning, faxing, or writing you. Please mark the ways that you consent to us communicating with you.

Communication Method	OK to Leave Voicemail?	OK to Leave Message with Another Person?	Preferred Method(s)	Best Time to Call
<input type="checkbox"/> Call Work Phone	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/>	
<input type="checkbox"/> Call Cell Phone	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/>	
<input type="checkbox"/> Call Home Phone	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/>	
<input type="checkbox"/> Send Email	<input type="checkbox"/> Okay for appt reminder? <input type="checkbox"/> Okay for medical/schedule information? <input type="checkbox"/> Okay for special offers including patient surveys and newsletter? No spam. We do not sell our lists.			
<input type="checkbox"/> Send US Mail to	Mail to <input type="checkbox"/> present address, <input type="checkbox"/> permanent address, <input type="checkbox"/> employer address, <input type="checkbox"/> emergency contact, <input type="checkbox"/> responsible party			
<input type="checkbox"/> Send Text Message Cell Phone Carrier:	<input type="checkbox"/> Okay for appt reminder? <input type="checkbox"/> Okay for medical/schedule information? <input type="checkbox"/> Okay for special offers?			

FAMILY MEMBERS				
Name	Date of Birth	Relationship	Release Results	Expiration or Comments

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my PHI by unsecured means. I understand that message and data rates may apply. I understand that I am not required to opt into emails or texting, or sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Patient Signature:

Date:

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## Health History

## Section I: Surgery and Anesthesia History

1. List and date your surgical history.

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2. Do you have a blood relative who had anesthesia complications of any kind?  No  Yes, please describe:

## Section II: Specific Medical History

## HEIGHT & WEIGHT:

Do you have a history of the following?

### **Section III: Social History**

1. Do you smoke?  No  Current Every Day Smoker  Current Some Day Smoker  
 Former Smoker---Quit date \_\_\_\_\_  Tobacco user  
 No  Yes

2. Do you Vape? If yes does it contain nicotine  No  Yes

3. How often do you drink alcohol?  Never  Monthly  Weekly  Daily  Socially

4. Number of children given birth to?  No  Yes, how many? \_\_\_\_\_

5. Do you drink caffeine?  Never  Occasionally  Daily

6. Illicit drug use?  No  Yes

7. Do you exercise?  Never  Weekly  Daily

## Section IV: Family History

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## Section V: Medications

List any medications, and oral or topical vitamins or herbal supplements you are taking.

**Do you have a Pain Contract with another physician?  No  Yes**

## Section VI: Allergies and Sensitivities

List all allergies and sensitivities:

**Reaction List:** 1) Arthralgia, 2) Chills, 3) Cough, 4) Fever, 5) Headache, 6) Hives, 7) Malaise/Fatigue, 8) Myalgia, 9) Nasal Congestion, 10) Other, 11) Pain/Soreness at injection site, 12) Rash, 13) Rhinorrhea, 14) Shortness of breath/Difficulty breathing, 15) Sore Throat, 16) Swelling, 17) Unknown

Are you allergic to medical adhesives such as tape, steri-strips, bandaids?  No  Yes, please list:

Are you allergic to any medications or local anesthesia?  No  Yes, please list:

## **Section VII: Women Only**

Date of last mammogram:	Number of pregnancies:			
Do you do regular breast self-exams?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you breast feed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Breast lump or discharge?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are you pregnant or trying to get pregnant?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are you on birth control pills or hormone replacement therapy?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

**I have read this questionnaire and disclosed my medical history to the best of my knowledge.**

Patient Signature:

Date:

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## Financial Policy

Appointment scheduling requires careful planning and coordination between our office, surgery centers and contracted staff. Special medical instrumentation and supplies may be ordered and are sterilized for each individual procedure. Please consider the importance of this policy before scheduling a procedure.

### SURGERY SCHEDULING

A \$1,000 down payment is required to secure a scheduled surgery time. **Full payment is due 21 days prior to a scheduled surgery date.** This includes complete payment of deductibles, co-insurance and copays for insurance cases. Immediately upon scheduling, patients have a **24-hour grace period** to make changes including cancelling the surgery without incurring a rescheduling/cancellation charge.

### SURGERY RESCHEDULING / CANCELLATION FEES

Patients who wish to change the surgery date or cancel surgeries, will incur a fee. Patients, who **fail a cotinine test**, are considered patient cancellations. Adequate notice of cotinine testing is always given, so there is no reason for a failed test. A rescheduling/cancellation fee will be assessed on failed cotinine tests. Fees are first withheld from any down payments already paid before invoicing the patient. The fee schedule is as follows:

Days Prior to Surgery	Rescheduling Fee	Cancellation Fee
Over 21 days	\$200.00	\$300.00
15-21 days	\$400.00	\$500.00
8-14 days	\$600.00	\$700.00
1-7 days	\$800.00	\$900.00
24 hours or less	\$1000.00	\$1000.00

### NON-SURGERY RESCHEDULING / CANCELLATION FEES

Generally, full payment is due on the day of service for non-surgical procedures such as those in the Renaissance Medispa and the Laser Institute of Wisconsin™. Some procedures have a non-refundable \$250 fee payable at the time of booking. The booking fee will be applied to the cost of the actual procedure, or used to cover the cost of consumables and room setup, if the patient cancels the appointment without adequate notice. You will be notified if your service requires a booking fee.

If you must cancel or change your non-surgical appointment, please notify us at least **24 hours** prior to your appointment time so that we can try to fill your slot with another patient. Without this advance notice, you will either forfeit your \$250 booking fee, if applicable, or be charged a **\$50 service fee**. This also applies to **no-shows**.

It is your responsibility to call us if you wish to reschedule. Your appointments, such as in veins, may have a sequential and cumulative sequence that must be followed. If one appointment is missed, the rest are timed incorrectly and must be rescheduled. If we cannot contact you, or you do not contact us, then all your remaining appointments will be cancelled.

**If you arrive late for your treatment, you may be asked to reschedule, so as not to delay the next scheduled client.**

### ALLOWABLE FORMS OF PAYMENT

Our office accepts payment by cash, check, money order and credit cards from Visa, Mastercard, Discover and American Express. We also offer patient financing through Care Credit and Alphaeon Credit. Not all patients will qualify for financing, and not all procedures are eligible to be financed.

### INSURANCE, CO-PAYS, DEDUCTIBLES

The patient or his/her legal representative is ultimately responsible for all charges incurred. Our office accepts assignment of benefits for many insurance companies. However, we are not preferred providers with all of them. It is your responsibility to **contact your insurance as to whether we are in your plan**, obtain your individual benefits and to be prepared to pay for any out-of-pocket expenses such as co-pays, deductibles and co-insurance before any surgery or office procedure is done. **Co-pays and past due balances are due at time of check-in.**

Your health care policy is a contract between you and your insurance company. If your insurance company does not cover your surgery, you will be liable for the payment. For example, Medicare does not have a pre-authorization process. If it is determined that your surgery was not medically necessary, you will then be billed for the surgery. It is ultimately **your responsibility to pay for all services** provided by Fox Valley Plastic Surgery.

If part or all my treatment is an insurance case, I verify that I have current insurance coverage, and directly assign to Fox Valley Plastic Surgery all medical benefits, if any, otherwise payable to me for services rendered. I understand I am

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financially responsible for any out-of-pocket expenses such as, but not limited to co-pays, deductibles and co-insurance.

#### **BILLING**

Statements are mailed monthly and expected to be paid in full within 60 days after your insurance has settled your claim. If you have financial difficulties, please contact our Financial Supervisor as soon as you are aware of the situation. The worst thing that you can do is to ignore the bill. Doing so will make you ineligible for any further service. If payment is not received within 90 days, your account may be referred to a collection agency.

#### **DISPUTES**

Performed services that are paid with a credit card, debit card or with financing, are not eligible for post-care payment challenges. Fox Valley Plastic Surgery encourages a complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I agree that this credit, debit card or financing challenge agreement is irrevocable.

I have read the above Financial Policy. I understand and agree to this.

Patient  
Signature: \_\_\_\_\_

Date: \_\_\_\_\_