Kerisma

Date____/____/_____

Name:_____ Date of Birth_____/_____/_____ Age_____ Sex M F

Address:_____ City:_____State:_____ Zip:_____

Hm Phone:_____ Wk Phone:_____

Cell Phone:_____E-mail:_____

Emergency contact:_____Phone:_____Relationship:_____

How were you referred to our office? _____May we contact you at home?_____Email_____Cell_____

Please check off the other procedures which are of interest to you.

☐ Botox ☐ Cosmetic Fillers ☐ Photo Rejuvenation ☐ Vein Treatment ☐ Ablation (stopflow) ☐ Lipo ☐ Breast Aug

HISTORY

Are you under the care of a physician at this time? ☐ Yes ☐ No If yes, what is the condition?_____

Do you use or have you used recreational drugs? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No

Are you on a special Diet? ☐ Yes ☐ No Height _____ Weight_____ Do you fluctuate in weight? _____

By how much?_____ Would you be interested in a weight loss program before/after surgery? ☐ Yes ☐ No

Have you taken the prescription drugs Fenfluramine, Fenfluramine combined with Phentermine? ☐ Yes ☐ No

(Fen-Phen), Dexfenfluramine (Redux), or other weight loss products? ☐ Yes ☐ No

Have you ever had any of the following?

Extensive bleeding which required special treatment? ☐ Yes ☐ No If yes, explain?_____

Medical cosmetic treatments? ☐ Yes ☐ No If yes, explain?_____

Lipo, Fractional or laser assisted surgery? ☐ Yes ☐ No If yes, explain?_____

Any complications with previous surgery? ☐ Yes ☐ No If yes, explain?_____

Abnormal or inguinal hernias? ☐ Yes ☐ No Blood transfusion? ☐ Yes ☐ No

Previous back injury or nerve injuries? ☐ Yes ☐ No Chronic viral infections? ☐ Yes ☐ No

Any family history of severe reaction to anesthesia or malignant hyperthermia? ☐ Yes ☐ No

Personal or family history of blood clots in legs or lungs or leg swelling? ☐ Yes ☐ No

Do you have any periodontal or dental disease? ☐ Yes ☐ No

Has a root canal be recommended to you? ☐ Yes ☐ No

Last pap? _____ Last Colonoscopy?_____ Last Bone density scan?_____Last Mammogram?_____

Ladies

How many pregnancies?_____Are you pregnant? ☐ Yes ☐ No

Method of contraception: ☐ Vasectomy ☐ Tubal ☐ Pill/Patch ☐ Injectable ☐ IUD ☐ Barrier ☐ Essure

Last menstrual period?_____How long is your period?_____

Do you experience bleeding between periods? ☐ Yes ☐ No

Drug Allergies:_____

Past Medical History

☐ Hypertension
☐ Diabetes
☐ Asthma
☐ Seizures
☐ Heart disease
☐ Stroke
☐ Cancer
☐ Liver Disease
☐ Hepatitis
☐ Kidney disorder
☐ Bleeding disorder
☐ Thyroid disease
☐ Cardiac pacemaker
☐ Cholesterol disorder
☐ HIV
Other_____

Past Surgical History/Year

☐ Gallbladder _____
☐ Tonsils _____
☐ Hysterectomy _____
☐ Heart Surgery _____
☐ Appendix _____
☐ Colon _____
☐ Other _____

Current Medications Name/Dosage

_____
_____
_____
_____
_____
_____
_____

Breast Augmentation Pre-Operative History
TO BE COMPLETED AT INITIAL CONSULTATION

PATIENT:_____ AGE:_____

CHIEF CONCERN/COMPLAINT: Breast Atrophy / Breast Asymmetry / Post pregnancy Involution / Breast Ptosis

Height_____ Weight (lbs)_____

Pertinent Past Medical History:

Medication Causing Adverse OR Allergic Reactions:

Prescription Medications Regular/ Intermittent:

OTC, Non-Prescription Meds, Herbal Remedies, Vitamins, Weight Loss Meds:

Previous Surgeries:

Which breast is larger? Right / Left / Neither.

Which breast is lower? Right / Left / Neither

Which breast is further from midline? Right / Left / Neither

Which nipple and areola are larger? Right / Left / Neither.

Which nipple and areola are lower? Right / Left / Neither

Which nipple and areola are further from the midline? Right / Left / Neither

Which breast do you like the best?

Please list the things you don't like about your breast.

Please list the things you want to change about your breast

LETTER OF MEDICAL CLEARANCE NEEDED? ○ YES ○ NO

Patient Signature_____ Date_____

KERISMA MD
10255 N 32ND STREET
PHOENIX, AZ 85028
Phone: 602 393 0661
Fax: 602 254 3474

Breast implant Surgery- Information
1 of 2

1. **Indications:**
The amount of breast development in an adult female varies considerably. Some women simply never develop a large amount of breast tissue. Others note that their breast tissue becomes noticeably less in amount following pregnancies. The majority of women seeking this surgery seek only to have normal size breast that relate to their body proportions, and are not seeking to be exceptionally buxom.

2. **How is the procedure done?**
The operation consists of developing a pocket behind the breast tissue. An implant is placed in this area, between the breast and muscle, under the muscle or the fascia covering the muscle. The implant pushes the breast forward and fills out loose skin. The most common way to gain access to the area behind the breast is through an incision approximately two inches long lying in the crease under the breast. Other approaches include making an incision in the axilla (arm pit) or around the nipple. These approaches will be discussed with you if you wish but it will cost more and have more side effects.

   The size of the implant to be used is determined by the amount of the existing breast tissue that you have and by your height, weight, and general body stature. The implant behind the breast should not interfere with future breast-feeding potential. There is probably no greater tendency to develop cysts or lumps in the breast with implants than without. Implants are not known to cause cancer. The FDA web site at http:/www.fda.gov/cdrt/breastimplants/index.html provides more instruction.

3. **Where is the operation done?**
This operation can be done on a short stay outpatient, or as an office procedure. In the facility, we will perform your procedure under local anesthesia. Whether the procedure is done in outpatient surgery or in the office, under local anesthesia you will be given sedation and you should have no pain with the procedure. Generally, there is little risk in the use of local anesthesia. However, in some cases there can be a reaction, varying from minor rashes to death. Local anesthesia is safer than general anesthesia, and has a quicker recovery without impaired healing. You will be sent home from observation with post-operative instructions.

4. **What may I do after the surgery?**
For the first few days you must rest and relax. You will be wearing the stretch bras without under-wiring and with a clasp in front (as we will recommend to you). You may make gentle minor adjustments in the bras and their straps as needed for comfort. You may sit or lie on your back or either side. You may get up to go to the bathroom and for meals. There should be no housework at all for the first full week. It is important to be cool and calm. Avoid overheating, contact with small children, excitement of any kind, and arms above the shoulders as needed in the first three days. Passive sexual activity may be resumed on the second day, but vigorous activity is NOT allowed for at least 4 weeks post- surgery.

   You may not shower until after your first post-op visit. You should wear the recommended bras most of the time in the first three to six weeks and especially in the first 3 weeks. Sutures will be removed no sooner than 2 weeks. The time for your next return appointment will be recommended to you after surgery, depending on your needs.

   Most of the discomfort will be over after 3-4 days. You may have some tenderness that will last for weeks to several months. After about a week, you may do light housework such as washing dishes. You should avoid hot baths and vigorous activity for at least 4 weeks, and should not participate in any sports such as jogging, swimming, bowling, tennis, etc. until 6 weeks after surgery.

Breast implant Surgery- Information
2of 2

5. **What complications can occur?**

As with any surgery, you can have a scar. Fresh scars are usually firm and red for a period of several months, and then they gradually improve over the period of about one year. The scar at the crease of the breast will generally be no more than 1/8 of an inch in width. It rarely would be wider than this and usually would be narrower than 1/8 of an inch. No guarantee can be made concerning the appearance of your scar. Each person heals differently and neither the physician nor the patient can control the patient's healing results. The scar will be permanent.

As with any operation, you might possibly develop an infection. Infection, if at all present, is generally limited to a very small area and simply results in delayed healing for a few days. The most serious infection possible would result in a total wound breakdown and would require removal of the implant. After a satisfactory period of healing (three to six months), the implant could be replaced.

Following the surgery, you may expect some "black and blue" discoloration especially near the incisions, but a larger amount of bleeding may result in a hematoma, which is a collection of clots around the implant. A hematoma is an unusual complication, but if present in a significant amount, the hematoma should be evacuated. This would require opening the incision and removal of the blood clots. The wound would then be re-closed. Hematomas, if they develop, usually are noticed in the first few days after surgery.

Numbness or tenderness of the nipples or skin around the incision may be present after surgery, but this is generally temporary. A permanent change in sensation of the nipples is uncommon.

Occasionally breasts become firm following implant surgery. The implant itself does not become firm, but the firmness is due to the formation of a capsule of scar tissue around the implant. If this capsule contracts excessively, it will squeeze the implant into a firm mass. While some firmness is beneficial to some patients, excessive firmness is not desirable. If excessive firmness develops, you may benefit by re-opening the incision and splitting the scar capsule, which has formed around the implant. You will be asked to do breast exercises to prevent this.

Inflatable implants have less of the firmness problem or capsules than silicone gel implants. It is possible, however, for the inflatable implants to leak and become smaller in size, requiring replacement. Approximately 10 years experiences with inflatable implants indicate at least a ten percent leakage rate.

6. On the morning of the operation, you should not smoke or eat a heavy meal.

7. Try to arrive near the schedule time. Think pleasant thoughts. You are not expected to have any discomfort at all. You should expect a pleasant experience without any pain.

8. Following surgery you will be observed in recovery. You may be ready to go home about 2 hours after your arrival. You must stay longer if needed. Additional instructions are available for the person taking you home. You should have a prescription for pain pills and an antibiotic to take after surgery. Call our office to ask for the prescription if you do not have it.

9. Arrange with the office for a time to be seen the next day, then in 2 weeks, three months and a year.

Signature_____ Date_____ Witness_____

Patient Communication Authorization

Date: _____

Patient's Name: _____

Date of Birth: _____

We must call on occasion to discuss confidential protected health information. Below is a list of potential ways for us to communicate this information. Please indicate how you would like us to get this information to you:

__ It's okay to call my home phone number Okay to leave a message? __ yes __no

__ It's okay to call my mobile number Okay to leave a message? __yes __no

__ It's okay to call my work phone number. Okay to leave a message? __yes __no

__ Call only this number. _____ Okay to leave a message? __yes __no

__ Do not speak to family members.

I give permission to the individual(s) listed below to receive protected health information:

_____

_____

This authorization can be revoked or modified by notifying us IN WRITING at any time.

Patient's Signature_____Date_____

PATIENT-PHYSICIAN ARBITRATION AGREEMENT

Section 1: I agree to binding arbitration to resolve any claim I may have against Keri Sweeten, M.D., or her staff. If I wish to assert a claim for medical malpractice, including any claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, I agree that such claim will be submitted to binding arbitration by the American Arbitration Association, and not by a lawsuit or resort to court proceedings. I agree that both parties to this contract are giving up their constitutional right to have any such claim decided in a court of law before a jury, and instead are agreeing to binding arbitration. I understand that binding arbitration means that a private arbitrator or arbitrators, and not a judge or jury, will decide my claim and that the arbitrator's decision ordinarily will be final.

Section 2: I agree that this Arbitration Agreement binds me and anyone else who may have a claim arising out of or related to the treatment or services provided by Dr. Sweeten or her staff, including my spouse or heirs and any children, whether born or unborn. This Agreement covers all claims for monetary damages including, without limitation, suits for loss of consortium and companionship, wrongful death, emotional distress and punitive damages. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this Agreement relates to claims against Dr. Sweeten and any employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of any parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement.

Section 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Section 4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE DR. SWEETEN'S SERVICES, AND THAT IF I DO SIGN THIS AGREEMENT AND LATER CHANGE MY MIND, I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO DR. SWEETEN WITHIN 30 DAYS STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT. I ALSO UNDERSTAND THAT I MAY HAVE MY ATTORNEY OR OTHER ADVISORS DISCUSS THIS AGREEMENT WITH DR. SWEETEN OR HER STAFF, AND THAT I OR ANY SUCH REPRESENTATIVE MAY REQUEST REVISIONS TO THIS AGREEMENT.

Section 5. OPTIONAL: RETROACTIVE EFFECT
If I intend this Agreement to cover services rendered before the date it is signed (for example, prior emergency treatment), I have indicated the earlier effective date below. Otherwise this Agreement covers only services rendered after this Agreement was signed.

Earlier effective date: _____ Patient's Initials: _____

Section 6. I have read and understood this Agreement. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

BY SIGNING THIS CONTRACT I AM AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND TO GIVE UP MY RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 of THIS CONTRACT.

_____ Dated: _____, 20____.
(Patient, Parent, Guardian or Legally Authorized Representative of Patient)

If signed by other than patient, indicate relationship: _____

PHYSICIAN'S AGREEMENT TO ARBITRATE
In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by arbitration on the terms set forth in this Agreement.

_____ Dated: _____, 20__.
(Physician or Duly-Authorized Representative)

_____ Dated: _____, 20__.
Print name of Physician, Medical Group, Partnership or Association

Information about our Arbitration Agreement.

To Our Valued Patients:

We would like to explain our policy regarding our Arbitration Agreement. We are concerned about the rising cost for medical liability insurance and the growing number of physicians who are leaving the practice of medicine because of the threat of malpractice litigation. It is our feeling that our Arbitration Agreement discourages frivolous litigation, and may help prevent increases in medical liability insurance premiums. Binding arbitration can also resolve claims more quickly and at less expense than court proceedings, and can avoid years of appeals. We believe this benefits both the patient and the physician.

The American Arbitration Association is a nationally-recognized organization which has qualified neutral arbitrators available to decide claims in a prompt and fair manner.

We are very grateful for your understanding and cooperation in this matter. Please feel free to discuss any concerns with our physicians or our office manager.

We will understand and respect your decision if you elect not to sign this Agreement. If you decide not to sign the Agreement, then we will happily see you in consultation today and for the next 30 days; after this 30-day period we would request that you seek further care with another physician. We can provide you with the names of other surgeons.

Sincerely,

Keri Sweeten, M.D.

Medication and Foods that Potentially Interact with Tumescent Anesthetic

Circle if you are taking any of the following:

Anesthetics
propofol (Diprovan)

Antibiotics/antimicrobials
clarithromycin (Biaxin)
chloramphenicol (Chloromycetin)
erythromycin
isoniazid
tetracycline
troleandomycin (TAO)

Anti-cardiac arrhythmia (antidysrhythmic) drugs
propafenone (Rythmol)
quinidine (Quinaglute, Quinidex)

Antidepressants
amitriptyline (Elavil) clomipramine (Anafranil) fluoxetine (Prozac) fluvoxamine (Luvox) nefazodone (Serzone) paroxetine (Paxil) sertraline (Zoloft)

Antiestrogen
tamoxifen (Nolvadex)

Antifungal Medications
fluconazole (Diflucan)
itraconazole (Sporanox)
ketoconazole (Nizoral)
metronidazole (Flagyl) miconazole (Monistat)

Antihistamines
astemizole (Hismanal)
terfenadine (Seldane)

Antiseizure medications
carbamazepine (Tegretol)
divalproex (Depakote)
valproic acid (Depakene)

Benzodiazepines
alprazolam (Xanax)
flurazepam (Dalmane)
midazolam (Versed)
triazolam (Halcion)

Beta blocker
propranolol (Inderal)

Beverage
grapefruit juice

Calcium channel blockers
amiodarone (Cordarone)
diltiazem (Cardizem) felodipine (Plendil) nicardipine (Cardene) nifedipine (Procardia) verapamil (Calan)

H_2 Blockers
cimetidine (Tagamet)

Hormones
thyroxine ethinylestradiol

Immunosuppressants
cyclosporine (Neoral, Sandimmune)

Miscellaneous
danozol (Danocrine)
methadone mibefradil (Posicor)
pentoxifylline (Trental)
zileuton (Zyflo)

Protease inhibitors
indinavir (Crixivan)
nelfinavir (Viracept)
ritonavir (Norvir)
saquinavir (Invirase)

Psychotherapeutic drugs
clozapine (Clozaril)
pimozide (Orap)

Steroidal Antiinflammatory drugs
dexamethasone (Decadron)
methylprednisolone
prednisone

Print Name _____

Patient Signature_____