MITESH KAPADIA, MD, PhD
OPHTHALMIC PLASTIC SURGERY

Name: _____ DOB_____ Today's Date:___/_____/_____

Address: _____ City:_____

State:_____ Zip Code:_____

Phone number(s): _____

Email address: _____

Primary Care Physician: _____ (Name and City)

How did you find us?

☐ Referred by another doctor: _____(Name and City)

☐ Referred by a patient: _____ (Name and City)

☐ Google search ☐ Realself.com ☐ Instagram ☐ Facebook

☐ Other: _____

1. Briefly describe why you are here:

_____

_____

2. Circle below if you have any of the following medical problems:

heart attack	stroke	artificial heart valve	skin cancer
cardiac stents	blood clots	irregular heartbeat	other cancer
high blood pressure	diabetes	thyroid disease	bleeding disorder

3. Please list all other medical problems:

_____

_____

_____

4. Circle any of the following medications or supplements you take regularly or occasionally.

aspirin	coumadin	plavix	pradaxa
alleve/naprosyn	eliquis	xarelto	turmeric/curcumin
other blood thinners	st. john's wart	celebrex	aggrenox
ginkgo baloba	vitamin e	motrin/ibuprofen	fish oil
accutaine	retin-a	garlic	

5. Please list all other medicines (prescription and non-prescription) not mentioned above. You do NOT need to list the dosages.

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

6. Please list medications which you are allergic to:

7. Do you currently smoke cigarettes? Yes ☐ No ☐, If yes: _____ packs per day for _____years.

8. Do you have problems with any of the following not already mentioned above?

Y	N		Y	N		Y	N	
☐	☐	sinuses	☐	☐	lungs/breathing	☐	☐	heart
☐	☐	urinary system	☐	☐	stomach/intestines	☐	☐	joints/muscles
☐	☐	skin	☐	☐	endocrine/glands	☐	☐	neurologic system

If yes, explain: _____

9. What is your occupation? _____

10. Are there any medical problems that run in your family? _____

11. Please list any prior eyelid surgeries or other cosmetic facial or body surgeries. Specify year and surgeon if possible.

12. Circle any of the following products or treatments you have had in the past

Botox/Dysport	Restylane	Juvederm	Sculptra/Radiesse
other facial fillers	skin lasers	chemical peel	Retin-A treatment
IPL treatments	microdermabrasion		microneedling

13. Circle any of the following areas which you may be interested in improving:

drooping/hooded eyelids	puffy eyelids	looking "tired"
hollowing in lower eyelids	excess eyelid skin	fine lines under and around eyes
lines between eyes (angry look)	dark circles under eyes	frown on corner of mouth
crease nose to corner of mouth	thin face, no cheeks	thin lips
lines around lips	brown spots on face	rosacea/red complexion
facial veins/blood vessels		

14. Circle any of the following products/treatments you may be interested in:

Botox/Dysport	Facial fillers	Laser hair removal
Vein removal	Intense Pulsed Light (IPL)	Laser skin resurfacing
Microneedling/RF microneedling	Chemical Peels	

15. Do you wear sunscreen daily

YES NO

16. Do you reapply sunscreen regularly when outdoors?

YES NO

17. Are you interested in learning about medical grade skin care for your specific skin type and needs?

YES NO

Do you follow our practice on Facebook or Instagram?

If not, please follow us **@Bostoneyelids** to learn more about sales, promotions, special pricing, events and new treatments.

MITESH KAPADIA, MD, PhD
OPHTHALMIC PLASTIC SURGERY

Mitesh Kapadia, M.D., Ph.D.
Notice of Privacy Practices Acknowledgement

I, _____, acknowledge I have received a copy of the notice of privacy practices.
(Please Print)

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian Date
If Patient is under 18

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COVID-19 RISK INFORMED CONSENT

I _____ (patient name) understand that I am opting for an elective treatment/procedure/surgery/office visit that is not urgent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr. Mitesh Kapadia and all the staff at his practice are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery/office visit. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery/office visit, and I give my express permission for Dr. Mitesh Kapadia and all the staff at his practice and surgical center to proceed with the same.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery/office visit can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery/office visit may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery/office visit, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

I have been given the option to defer my treatment/procedure/surgery/office visit to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery/office visit. I understand that this consent will remain in effect for the duration of the COVID-19 pandemic.

_____ _____

Patient Name Date