PATIENT REGISTRATION INFORMATION

COMPREHENSIVE MEDICAL HISTORY for COSMETIC PROCEDURES Date: _____/_____/_____

*** PLEASE ANSWER ALL QUESTIONS OF THIS FORM AND THEN SIGN***

First Name: _____Middle: _____Last Name: _____
Address:_____
City:_____ State:_____ Zip_____
Home Phone (____)_____ Work Phone (___)_____ Cell Phone (___)_____
Date of Birth: _____/_____/_____ Social Security Number:_____-_____-_____
Best time to contact me is:_____ ☐ morning ☐ afternoon ☐ evening **at** ☐ Home ☐ Work ☐ Cell.

☐ Okay to leave voicemail? ☐ Okay to send Text? ☐ Okay to send email? ☐ Sign me up for Specials?

Employer_____ Work Phone_____

Family Doctor: _____.Group Practice Name: _____Phone _____
Family Doctor Address: _____
Emergency contacts: 1. _____ Phone_____
Provide email & you can access your health records online securely:_____

How did you hear about us?

☐ Our Website ☐ Friend ☐ Facebook ☐ Google ☐ Bing ☐ Radio ☐ Billboard ☐ TV
☐ Walk-in ☐ Phone book ☐ Newspaper / Print ☐ Digital Advertising ☐ Other _____

Reason for visit including areas of concern: Please list when condition (s) started, is it better or worse now? What tests/ treatments have been done? Any Medications started? _____

_____

_____

Current diet and exercise plan: _____
What role has diet and exercise played? _____
Has your weight remained stable in the last 10 years? Y N. Max Weight = _____ Minimum Weight = _____
Please explain weight changes: _____

_____

Past Surgical History (please check all that apply & add date of surgery) □ **No Prior Surgery**

__Abdominoplasty (Tummy Tuck)	__Endometrial Ablation	__Liposuction
__Aortic Aneurysm	__Facelift	__Lumbar (Disc) Surgery
__Appendectomy	__Foot Surgery	__Lung Surgery
__Breast Reduction	__Gallbladder	__Neck surgery
__Breast Lift	__Gastroscopy	__Pacemaker
__Breast Augmentation (implants)	__Gastric Bypass	__Prostate Surgery
__Breast Fat Transfer	__Gastric Sleeve	__Shoulder Surgery
__Carotid Surgery, R or L	__Heart Bypass	__Splenectomy (↑DVT, PE)
__Cataract/Eye	__Heart Angioplasty/Stents	__Stomach Surgery
__Carpal Tunnel	__Hernia	__Thyroid Surgery
__Colonoscopy	__Hip Surgery	__Tonsillectomy
__Colon surgery	__Hysterectomy	__Ovarian Tubal Ligation
__C-Section	__Knee Surgery	__Vascular Surgery, R or L
__D & C	__Laparoscopy, Diagnostic	__Vein Surgery, R or L

__Urinary Bladder Any Other Surgeries _____
Any prior Transfusions? Y N. Any problems with anesthesia? Y N. Explain _____

Past Medical History (please **check** all that apply) (please circle **Active** for all that are currently being treated)

__Abnormal Healing`	Active	__Anorexia	Active	__Bladder Infections	Active
__Acid Reflux (GERD)	Active	__Arthritis	Active	__Blood Disorder	Active
__Anemia	Active	__Asthma	Active	__Bronchitis	Active

__Cancer	Active	__Irregular Heart	Active	__Seizures	Active
__Chest pain (angina)	Active	__Kidney disease	Active	__Shortness of breath	Active
__Cold sores	Active	__Liver Disease	Active	__Sinus problems	Active
__Dentures	Active	__Lymphedema	Active	__Sleep Apnea	Active
__Depression	Active	__Malignant Hyperthermia		__Stroke/TIA	Active
__Diabetes	Active	__Motion sickness	Active	__Thyroid disease	Active
__Fibromyalgia	Active	__Nausea/Vomiting	Active	__TMJ syndrome	Active
__Gout	Active	__Neuropathy	Active	__Tuberculosis	Active
__Heart Attack	Active	__Oxygen use	Active	__Ulcers, stomach	Active
__Hepatitis	Active	__Palpitations	Active	__Varicose veins	Active
__Hernia	Active	__Pancreatitis	Active	__Vision Problems	Active
__High Blood Pressure	Active	__PCOS-Polycystic Ovarian	Active	Other_____	
__HIV	Active	__Recreational drugs	Active	Other_____	
__Insomnia	Active	__Scarring/Keloids	Active	Other_____	

Review of Systems (Please underline or circle all that apply)

- **Constitutional:** Fever, chills, night sweats, trouble swallowing, weight loss/gain _____lbs.. Insomnia.
- **Skin:** Ulcers, Rash, Itching, Cellulitis, Melanoma, Skin Cancer, Eczema, Psoriasis
- **Eyes:** Temporary loss of vision in one eye, Blurred Vision, Cataracts, Glasses, Macular Degeneration.
- **ENT:** Dentures, Ear Problems, Hearing Aid, Nose Bleeds, Congestion, Swallowing Problems
- **Cardiac:** Chest Pain, Angina, Chest pain with exertion, Palpitations, Leg swelling, Ankle swelling, Leg pain, leg pain at rest, leg pain with activity, last stress test _____, Echocardiogram _____
- **Respiratory:** Short of breath (SOB), Wheezing, SOB when lying flat, Cough, change in voice/hoarseness.
- **GI:** Nausea, Vomiting, Diarrhea (stool per day_____), Constipation (On average, stool every day _____), Abdominal pain, Blood in stool, black stool , Heartburn, acid Reflux, Colon Polyps
- **Nutrition:** Generally I eat 'junk food'. Low or Hi carbohydrate diet. <1or >1 8oz soft drink/day, high or low fiber diet, high or low fat diet.
- **GU:** Burning when urinate, frequency, urgency, Prostate problems, Kidney disease, Genital Warts, Herpes
- **GYN:** # of Pregnancies _____, # of Births _____, # of miscarriages/abortions _____.
  Last menstrual period ___/___/_____. Painful intercourse. __Irregular, __light, __ medium __heavy menstrual periods. Approximate age at menopause _____. Last pelvic ____/____/_____ Last Pap smear ____/____/_____
- **Breast: Last mammogram:** ____/_____ Breast lumps: Yes No. Nipple discharge: Yes No. Bloody: Yes No. Breast infections: Yes No, Breast pain: Yes No. Breast fed: Yes No.
- **Musculoskeletal:** Pain legs/calf with walking, Sciatica, back pain, back disc disease, joint pain, neck pain.
- **Neurologic:** Dizzy, lightheaded, weak or numb one side- arm/leg/face, headache, passing out.
- **Psych:** Depression, Anxiety, Psychosis, rehab for drug or alcohol abuse, Dementia, Bipolar
- **Endocrine:** Excessive thirst or urination, Thyroid disease
- **Heme/Immune:** HIV/AIDS, Hepatitis A, B, C, easy bruising, clotting disorder, bleeding problems in past.
- **Trouble with Leg Swelling / Leg Edema?** _____
- **Any history of Radiation:** No Yes When & Where: _____
- **Any prior history of cancer?**-Explain: _____

Medications: List all medications, dosages, frequency, and include all natural supplements: _____

_____

_____

_____

_____

Any History of 'Panic' or 'Anxiety' attacks? Yes No Last attack? _____
Any history of Staph or MRSA infections? Yes No Last episode? _____
Any bleeding problems? Yes No
Explain: _____
Use of any Diet Pills: (phentermine) Yes No Last time: _____

Latex Allergy: Yes No Explain: _____
Xylocaine "caine" any local anesthetic Allergy: Yes No
Drug Allergies: _____
Environmental Allergies: _____
Social History: Check all that apply: Alcohol: Yes No. How much? _____
Tobacco: (check) __ Smoke: __ Dip ___ Chew ___ eCig ___ Cigars. How much & how long? _____
If you quit, when? _____
History of Substance / Drug Abuse or Alcohol Abuse? No If Yes Explain: _____
_____

Internal Defibrillator or Pacemaker? □ NO □ YES

Yes No 1. Do you understand that the use of alcohol, drug abuse, and especially tobacco, E-cig, and/or marijuana within a month prior and up to 2 months after any surgical procedure will increase your risks of wound complications including skin necrosis, poor healing, infections, and poor results?

Yes No 2. Do you understand that the surgical procedure may not be done or may be done in a less aggressive fashion to potentially avoid possible complications due to tobacco /marijuana /ecig use?

Yes No 3. There is no guarantee from complications?

Live Alone ____. Employed ____. Disabled ____. Retired ____. Student ____. Homemaker ____. Married ____. Divorced ____. Widowed ____. Single never married____.

Family History: Please specify which family member (s): □ Cancer □ Bleeding Disorder □ Diabetes □ Hypertensions □ Heart Problems □ Aneurysm □ Stroke □ Varicose Veins Explain: _____
_____
Other Information by Patient _____
_____

Patient Signature: _____ Date: _____/_____/_____

Provider Notes:
_____
_____
_____
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Physician Reviewed- Signature: _____ Date: _____/_____/_____