



## PATIENT REGISTRATION FORM

The following information will help us serve you better. Please make every effort to fill out the information fully and accurately. Your responses are kept strictly confidential.

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ SSN \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE Home \_\_\_\_\_ Work \_\_\_\_\_

Cell \_\_\_\_\_ E-mail \_\_\_\_\_

Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( )

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EDUCATION (highest year completed) \_\_\_\_\_

NAME OF SPOUSE OR PARENT \_\_\_\_\_

SPOUSE EMPLOYER \_\_\_\_\_ SPOUSE OCCUPATION \_\_\_\_\_

EMERGENCY CONTACT Name \_\_\_\_\_ Telephone number \_\_\_\_\_

Relationship \_\_\_\_\_

WHO IS RESPONSIBLE FOR CHARGES? \_\_\_\_\_

**Please Circle below the primary type of surgery you are interested in discussing today:**

FACE EYES NOSE LIPS CHIN CHEEKS EARS NECK WRINKLES SCARS

BREAST ENLARGEMENT BREAST LIFT BREAST REDUCTION TUMMY TUCK LIPOSUCTION

BUTTOCK ENLARGEMENT THIGH LIFT ARM REDUCTION

OTHER \_\_\_\_\_

# COSMETIC INTEREST QUESTIONNAIRE

**Our practice is constantly striving to offer you the safest, most advanced procedures for facial rejuvenation and overall physical improvement. Please check any of the following health issues you would like to receive more information on, either a brochure or consultation.**

- |   |  |
|---|--|
| <input type="checkbox"/> Fine lines and wrinkles (Botox)        | <input type="checkbox"/> Breast Augmentation (enlargement) |
| <input type="checkbox"/> Facial Fillers                         | <input type="checkbox"/> Breast Reduction                  |
| <input type="checkbox"/> Eyelashes; Longer, Fuller, Darker      | <input type="checkbox"/> Breast Lift                       |
| <input type="checkbox"/> Laser hair removal                     | <input type="checkbox"/> Gynecomastia                      |
| <input type="checkbox"/> Overall Skin Rejuvenation              | <input type="checkbox"/> Tummy Tuck                        |
| <input type="checkbox"/> Eyelid Surgery (Blepharoplasty)        | <input type="checkbox"/> Forehead/Brow Lift                |
| <input type="checkbox"/> Facelift                               | <input type="checkbox"/> Cheek Implants                    |
| <input type="checkbox"/> Chin Surgery                           | <input type="checkbox"/> Scar removal                      |
| <input type="checkbox"/> Laser treatments with no downtime      | <input type="checkbox"/> Lip augmentation                  |
| <input type="checkbox"/> Laser skin resurfacing                 | <input type="checkbox"/> Hollywood Style Liposuction       |
| <input type="checkbox"/> Age spots/facial pigmentation problems | <input type="checkbox"/> Liposuction                       |
| <input type="checkbox"/> OTHER _____                            |  |

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number:

- ◆ When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of wrinkles on my face.

**Not Concerned**

**1**

**2**

**Somewhat Concerned**

**3**

**4**

**Very Concerned**

**5**

- ◆ When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my body.

**Not Concerned**

**1**

**2**

**Somewhat Concerned**

**3**

**4**

**Very Concerned**

**5**

Would you like to receive announcements on special discounts, new products or procedures?

- YES                       NO

If YES, what address can we send it to? \_\_\_\_\_

Would you like to receive this information via an email address?

- YES                       NO

If YES, please list email address ([name@example.com](mailto:name@example.com)) \_\_\_\_\_

**PLEASE LET US KNOW HOW YOU FOUND US**

- ( ) Patient referral. May we ask who? \_\_\_\_\_
- ( ) Doctor referral. May we ask who? \_\_\_\_\_
- ( ) Advertisement. Where? \_\_\_\_\_
- ( ) Web Site. \_\_\_\_\_

**The medical history is an extremely important part of your consultation. It helps to alert us to any potential problems that might interfere with your surgery. Please take the time to fill this out completely and accurately. If you need some help, the staff will be glad to assist you.**

**LIST ANY MEDICAL CONDITIONS YOU MAY HAVE**

- ( ) High blood pressure ( ) Heart disease ( ) Asthma/Emphysema ( ) Diabetes ( ) Cancer
  - ( ) Bleeding disorders ( ) Chronic skin conditions ( ) Emotional problems ( ) Shortness of breath
  - ( ) Neurological problems ( ) Kidney problems ( ) Glaucoma or other eye problems ( ) Chest pain
  - ( ) Endocrine disorders ( ) Other \_\_\_\_\_
- \_\_\_\_\_

**LIST ANY SURGERIES YOU HAVE HAD**

\_\_\_\_\_

\_\_\_\_\_

**ARE YOU ALLERGIC TO ANY DRUGS/FOODS/LATEX? YES ( ) NO ( )** If yes, please explain:

\_\_\_\_\_

**PLEASE LIST ALL MEDICATION YOU ARE CURRENTLY TAKING**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE LIST ANY HERBAL OR NATURAL SUBSTANCES/DIET PILLS /OVER THE COUNTER MEDICATIONS**

\_\_\_\_\_

DO YOU SMOKE? ( ) YES ( ) NO If yes, how much? \_\_\_\_\_

DO YOU DRINK ALCOHOL? ( ) YES ( ) NO If yes, how much? \_\_\_\_\_

HAVE YOU HAD ANY DIFFICULTIES WITH GENERAL ANESTHESIA? ( ) YES ( ) NO

If yes, please explain: \_\_\_\_\_

PLEASE LIST ANY CHRONIC MEDICAL PROBLEMS WHICH RUN IN YOUR FAMILY

\_\_\_\_\_

HAVE YOU EVER BEEN PREGNANT? ( ) YES ( ) NO If yes, how many children do you have? \_\_\_\_\_

Vaginal delivery  C-section

DO YOU HAVE A PRIMARY CARE DOCTOR? ( ) YES ( ) NO If yes, please provide the following:

Doctor's name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ Fax \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

HOW TALL ARE YOU? \_\_\_\_\_ HOW MUCH DO YOU WEIGH? \_\_\_\_\_ BRA SIZE \_\_\_\_\_

HOW IS YOUR GENERAL HEALTH? ( ) Excellent ( ) Good ( ) Poor

PLEASE PROVIDE US WITH ANY ADDITIONAL INFORMATION YOU FEEL MAY BE IMPORTANT

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have read and completed this form completely and accurately to best of my ability:

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_