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Patient Registration Form

Patient Information:

Name: _____ Date of Birth: _____
First M.I. Last

Reason for Consultation: _____ Referred By: _____

Would you be interested in: ___ Botox ____ Filler ___ Facial Laser Micropeel

Allergies: _____

Do You Smoke? Yes ____ No____ Are you an Ex-smoker? Yes_____ No_____

Current Medications (INCLUDING NON-PRESCRIPTION DRUGS, VITAMINS AND HERBALS):

_____

List previous surgeries or major illnesses and dates (including any plastic surgery):

_____

Family History:
Has any blood relative ever had any of the following:

Breast Cancer…..no	yes	High Blood Pressure…..no	yes	Kidney Disease…..no	yes
Melanoma…..……no	yes	Heart Disease……no	yes	Depression…..……..no	yes
Stroke……..….no	yes	Diabetes……..…….….no	yes		

Past Medical History:
Have you ever had the following:

Heart disease…..no	yes	Cancer……no	yes	Stomach Ulcer……..no	yes		
Arthritis……..no	yes	Glaucoma……...no	yes	Kidney Disease…….no		yes	
Rheumatic fever...no	yes	Asthma……. ...no	yes	Thyroid Disease……no		yes	
Anemia……...no	yes	AIDS/HIV+……..….no	yes	Bleeding Tendency…...no		yes	
Tuberculosis……..no	yes	Stroke……..….no	yes	Mitral Valve Prolapse…no	yes		
Diabetes……no	yes	Hepatitis……..….no	yes	High Blood Pressure….no		yes	
Substance abuse problems (Drugs or Alcohol)……....no			yes				

Review of Systems:
Do you have now or have you had within the last year:

Weight Change...no	yes	Swollen feet/ankles……no	yes	Seizures…….no	yes
Dry eyes……...no	yes	Skin rash……no	yes	Joint or muscle pain…..no	yes
Chronic cough….no	yes	Chronic Diarrhea……no	yes	Swollen lymph nodes…no	yes
Chest pain……...no	yes	Jaundice……..no	yes	Easy bleeding……no	yes
Rapid heart beat..no	yes	Depression……..no	yes	Easy bruising…….no	yes

Women only:

Breast lump……no	yes	Breast Discharge…….no	yes

Date of last mammogram_____ Number of pregnancies_____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X_____ _____
Signature of patient or parent if minor Date