SEAN DOHERTY, M.D., FACS
www.seandohertymd.com
info@seandohertymd.com
69 Newbury Street • 5th Floor • Boston, MA 02116 • (617) 450-0070 One
Brookline Place • Suite 427 • Brookline, MA 02445 • (617) 735-8735

NEW PATIENT REGISTRATION

PATIENT INFORMATION

Name _____ Date of Birth _____ Age _____

Address _____ Home Phone ( ) _____

City _____ State _____ ZIP _____ Cell Phone ( ) _____

Social Security # _____ Marital Status _____ Sex _____

Which number do you prefer to be contacted on? Home ❑ Cell ❑ Work ❑

E-mail Address: _____ (optional)

EMPLOYMENT

Occupation _____ Employer _____

Address _____

City _____ State _____ Zip _____ Work Phone ( ) _____

REFERRED BY

Name _____

Address _____

City _____ State _____ Zip _____ Phone ( ) _____

EMERGENCY CONTACT

Name _____ Relationship _____

Address _____ Home Phone ( ) _____

City _____ State _____ Zip _____ Work Phone ( ) _____

PRIMARY CARE PHYSICIAN

Name _____ Phone ( ) _____

Address _____

City _____ State _____ Zip _____

THE FOLLOWING AGREEMENT MUST BE SIGNED BY ALL PATIENTS AND/OR GUARDIANS
I assume full responsibility for, and agree to prompt and full payment of, all charges incurred by me (or person for whom I am legally responsible).

Signature: _____ **Today's Date:** _____

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HEALTH HISTORY

Name _ Height _ Weight: _

Purpose of visit/procedure: _

In addition to this consultation, are there any other procedures that would interest you?
i.e.: lasers, injectable fillers, skincare, etc. ❑ Yes ❑ No

List operations in the past: _

Are you allergic to any of the following?

YES	NO		YES	NO		YES	NO	
❑	❑	Barbituates	❑	❑	Jewelry	❑	❑	Sulfa Drugs
❑	❑	Codeine	❑	❑	Latex	❑	❑	Tetracycline
❑	❑	Erythromycin	❑	❑	Penicillin	❑	❑	Other

Do you have any allergies to anesthesia? ❑ Yes ❑ No
If yes, please explain: _
Do you have an allergy to tape? ❑ Yes ❑ No

Please list additional drugs/items that cause allergic reactions: _

Your current physical health is: ❑ Good ❑ Fair ❑ Poor
Are you currently under the care of a physician? ❑ Yes ❑ No
Are you being treated for a medical condition? ❑ Yes ❑ No

If yes, please explain: _
_ Have you seen other plastic surgeons for the same problem which brings you here today? ❑ Yes ❑ No

Do you presently or have you ever experienced the following?

YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
❑	❑	Abnormal Bleeding	❑	❑	Congenital Heart Defect	❑	❑	Hay Fever	❑	❑	Liver Problems	❑	❑	Sickle Cell Disease
❑	❑	Anemia	❑	❑	Diabetes	❑	❑	Heart Trouble	❑	❑	Low Blood Pressure	❑	❑	Sinus Problems
❑	❑	Acid Reflux / Gerd	❑	❑	Emphysema	❑	❑	Hemophilia	❑	❑	Lupus	❑	❑	Stroke
❑	❑	Arthritis	❑	❑	Epilepsy	❑	❑	Hepatitis	❑	❑	Mitral Valve Prolapse	❑	❑	Shingles
❑	❑	Asthma	❑	❑	Fainting Spells	❑	❑	Herpes	❑	❑	Pacemaker	❑	❑	Thyroid Problems
❑	❑	Cancer	❑	❑	Fever Blisters	❑	❑	High Blood Pressure	❑	❑	Radiation Treatment	❑	❑	Tuberculosis (TB)
❑	❑	Chemotherapy	❑	❑	Glaucoma	❑	❑	Kidney Problems				❑	❑	Ulcers

Do you smoke or use tobacco in any form? ❑ Yes ❑ No
Do you drink alcoholic beverages? ❑ Yes ❑ No
Do you use recreational drugs? ❑ Yes ❑ No
Do you take aspirin? ❑ Yes ❑ No
Do you take anti-inflammatory drugs such as: Ibuprofin, Advil, Aleve, etc. ❑ Yes ❑ No

Do you wear contact lenses? ❑ Yes ❑ No
Do you bleed easily from cuts or surgery? ❑ Yes ❑ No
Do you form large scars or keloids? ❑ Yes ❑ No
Do you have frequent boils or infections? ❑ Yes ❑ No
Have you ever had previous cosmetic surgery? ❑ Yes ❑ No

Please explain any other serious medical condition(s) that you have experienced: _

Medications: List all medications you are taking (including non-prescription):

	Name	Dosage	How Often Taken
1.			
2.			
3.			

For Women:

If applicable to this visit, please state bra size: _
# of pregnancies _ # of children delivered _
Are you pregnant? ❑ Yes ❑ No ❑ Unsure
You cannot have surgery if you are pregnant.
List any form of cancer - breast, cervical, ovarian, other: _

BOSTON CENTER FOR FACIAL REJUVENATION

FACIAL REJUVENATION

WHAT ARE YOUR CONCERNS? (PLEASE CHECK ALL THAT

__ Frown lines between the brows Significant
__ lines around nose and mouth Sunken cheeks
__ Facial hair
__ Acne
__ Freckles and age spots
__ Fine lines and wrinkles
__ Rough sun damaged skin texture
__ Sagging skin (face and neck)
__

__ Hyperpigmentation Dark
__ circles under eyes Dry
__ skin
__ Jowls
__ Lips
__ Pores
__ Eyelashes
__ Facial veins

ARE YOU INTERESTED IN LEARNING MORE ABOUT THE FOLLOWING?

__ Botox Cosmetic
__ Injectable Fillers
__ Skin care advice
__ Skin care products
__ Hair removal
__ Eyelash growth products
__ Chemical peels (TCA)
__ Facial and Eye treatments
__ Makeup
__ Laser skin resurfacing

__ Laser treatments Spider
__ vein treatment Acne
__ treatments Retin A
__ Renova
__ Vitamin Creams
__ Skin rejuvenation
__ Sun protection
__

Other, please specify _____

ARE YOU INTERESTED IN MEETING ONE OF OUR COSMETIC SKIN CARE CONSULTANTS IN ORDER TO CREATE PERSONAL TREATMENT PLAN DESIGNED TO MEET YOUR COSMETIC

__ Yes __ No

WHEN LOOKING AT MY FACE IN THE MIRROR, I BELIEVE I LOOK YOUNGER, THE SAME AS, OR OLDER THAN MY TRUE AGE.

Younger Than		True Age		Older Than
1	2	3	4	5

WHEN LOOKING IN THE MIRROR, I AM NOT CONCERNED, SOMEWHAT CONCERNED, OR VERY CONCERNED ABOUT THE APPEARANCE OF MY WRINKLES.

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

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