

SEAN DOHERTY, M.D., FACS

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## NEW PATIENT REGISTRATION

### PATIENT INFORMATION

Name \_\_\_\_\_ Date of Blrth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Home Phone (     ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Cell Phone (     ) \_\_\_\_\_

Social Security # \_\_\_\_\_ Marltal 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 \_\_\_\_\_

Clty \_\_\_\_\_ 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: \_\_\_\_\_

**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   |
| <input type="checkbox"/> <input type="checkbox"/> Barbituates  | <input type="checkbox"/> <input type="checkbox"/> Jewelry    | <input type="checkbox"/> <input type="checkbox"/> Sulfa Drugs  |
| <input type="checkbox"/> <input type="checkbox"/> Codeine      | <input type="checkbox"/> <input type="checkbox"/> Latex      | <input type="checkbox"/> <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> <input type="checkbox"/> Erythromycin | <input type="checkbox"/> <input type="checkbox"/> Penicillin | <input type="checkbox"/> <input type="checkbox"/> 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 If yes, please explain: \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No \_\_\_\_\_ Have \_\_\_\_\_ you

Are you being treated for a medical condition?  Yes  No 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  |
| <input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding  | <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> <input type="checkbox"/> Liver Problems        | <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> <input type="checkbox"/> Anemia             | <input type="checkbox"/> <input type="checkbox"/> Diabetes                | <input type="checkbox"/> <input type="checkbox"/> Heart Trouble       | <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> <input type="checkbox"/> Sinus Problems      |
| <input type="checkbox"/> <input type="checkbox"/> Acid Reflux / Gerd | <input type="checkbox"/> <input type="checkbox"/> Emphysema               | <input type="checkbox"/> <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> <input type="checkbox"/> Lupus                 | <input type="checkbox"/> <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis          | <input type="checkbox"/> <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Shingles            |
| <input type="checkbox"/> <input type="checkbox"/> Asthma             | <input type="checkbox"/> <input type="checkbox"/> Fainting Spells         | <input type="checkbox"/> <input type="checkbox"/> Herpes              | <input type="checkbox"/> <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems    |
| <input type="checkbox"/> <input type="checkbox"/> Cancer             | <input type="checkbox"/> <input type="checkbox"/> Fever Blisters          | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis (TB)   |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy       | <input type="checkbox"/> <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> <input type="checkbox"/> Kidney Problems     |   | <input type="checkbox"/> <input type="checkbox"/> Ulcers              |

Do you smoke or use tobacco in any form?  Yes  No Do you wear contact lenses?  Yes  No

Do you drink alcoholic beverages?  Yes  No Do you bleed easily from cuts or surgery?  Yes  No

Do you use recreational drugs?  Yes  No Do you form large scars or keloids?  Yes  No

Do you take aspirin?  Yes  No Do you have frequent boils or infections?  Yes  No

Do you take anti-inflammatory drugs such as: Ibuprofen, Advil, Aleve, etc.  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 List any form of cancer - breast, cervical, ovarian, other: \_\_\_\_\_

You cannot have surgery if you are pregnant. \_\_\_\_\_



**FACIAL REJUVENATION**

**WHAT ARE YOUR CONCERNS? (PLEASE CHECK ALL THAT**

- |  |   |
|--|---|
| <input type="checkbox"/> Frown lines between the brows Significant | <input type="checkbox"/> Hyperpigmentation Dark |
| <input type="checkbox"/> lines around nose and mouth Sunken cheeks | <input type="checkbox"/> circles under eyes Dry |
| <input type="checkbox"/> Facial hair                               | <input type="checkbox"/> skin                   |
| <input type="checkbox"/> Acne                                      | <input type="checkbox"/> Jowls                  |
| <input type="checkbox"/> Freckles and age spots                    | <input type="checkbox"/> Lips                   |
| <input type="checkbox"/> Fine lines and wrinkles                   | <input type="checkbox"/> Pores                  |
| <input type="checkbox"/> Rough sun damaged skin texture            | <input type="checkbox"/> Eyelashes              |
| <input type="checkbox"/> Sagging skin (face and neck)              | <input type="checkbox"/> Facial veins           |
| <input type="checkbox"/>   |   |

**ARE YOU INTERESTED IN LEARNING MORE ABOUT THE FOLLOWING?**

- |  |  |
|--|--|
| <input type="checkbox"/> Botox Cosmetic            | <input type="checkbox"/> Laser treatments Spider |
| <input type="checkbox"/> Injectable Fillers        | <input type="checkbox"/> vein treatment Acne     |
| <input type="checkbox"/> Skin care advice          | <input type="checkbox"/> treatments Retin A      |
| <input type="checkbox"/> Skin care products        | <input type="checkbox"/> Renova                  |
| <input type="checkbox"/> Hair removal              | <input type="checkbox"/> Vitamin Creams          |
| <input type="checkbox"/> Eyelash growth products   | <input type="checkbox"/> Skin rejuvenation       |
| <input type="checkbox"/> Chemical peels (TCA)      | <input type="checkbox"/> Sun protection          |
| <input type="checkbox"/> Facial and Eye treatments | <input type="checkbox"/>                         |
| <input type="checkbox"/> Makeup                    | Other, please specify _____                      |
| <input type="checkbox"/> Laser skin resurfacing    | _____  |

**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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