

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	Do you have any allergies to anesthesia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <input type="checkbox"/> Barbituates	<input type="checkbox"/> <input type="checkbox"/> Jewelry	<input type="checkbox"/> <input type="checkbox"/> Sulfa Drugs	If yes, please explain: _____		
<input type="checkbox"/> <input type="checkbox"/> Codeine	<input type="checkbox"/> <input type="checkbox"/> Latex	<input type="checkbox"/> <input type="checkbox"/> Tetracycline	Do you have an allergy to tape?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <input type="checkbox"/> Erythromycin	<input type="checkbox"/> <input type="checkbox"/> Penicillin	<input type="checkbox"/> <input type="checkbox"/> Other			

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 seen other plastic surgeons for the same problem which brings you here today? Yes No

Are you being treated for a medical condition? 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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