



John Q. Cook, M.D.
Aesthetic Plastic Surgeon

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SURGICAL PATIENT REGISTRATION AND CONSENT FOR TREATMENT FORM

PATIENT INFORMATION

_____ (_____) _____
 MR/MRS/MS PREFERRED FIRST NAME TITLE HOME PHONE

_____ (_____) _____
 FIRST NAME M.I. LAST NAME WORK PHONE

_____ (_____) _____
 ADDRESS APT. MOBILE PHONE

_____ (_____) _____
 CITY STATE ZIP PAGER

_____ (_____) _____
 SOCIAL SECURITY NUMBER SINGLE MARRIED OTHER OTHER

_____ (_____) _____
 BIRTH DATE AGE MALE FEMALE FAX

I would like Dr. Cook to keep me informed about Advances in Plastic Surgery via email.

 E-MAIL ADDRESS

REFERRAL INFORMATION

REFERRED BY PATIENT REFERRED BY PHYSICIAN REFERRED BY PATIENT REFERRED BY PHYSICIAN

 REFERRAL SOURCE 1 NAME REFERRAL SOURCE 2 NAME

 ADDRESS (IF AVAILABLE) ADDRESS (IF AVAILABLE)

 CITY STATE ZIP CITY STATE ZIP

 PRIMARY CARE PHYSICIAN NAME

EMERGENCY CONTACT

 FIRST NAME LAST NAME

 RELATIONSHIP

_____ (_____) _____
 HOME PHONE

_____ (_____) _____
 WORK PHONE

SPOUSE

 FIRST NAME LAST NAME

 SPOUSE'S EMPLOYER

_____ (_____) _____
 SPOUSE'S PHONE



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MEDICAL HISTORY QUESTIONNAIRE
(please print)

PATIENT NAME:

-What type of plastic surgery are you interested in discussing? _____

-Who referred you to me? _____

May I send a thank-you letter to them? YES NO

-Do you know anyone who has undergone the procedure you are interested in? YES NO

-Have you done any reading about the procedure you are interested in? YES NO

-Have you ever had a plastic surgery procedure before? YES NO

if yes, please describe the type of surgery you had and your experience:

-Have you ever undergone surgery? YES NO

if yes, please list previous surgeries and the approximate date:

-Did you have any unusual experiences after previous surgery, such as bleeding, reactions to medications, prolonged hospitalization or any departure from the expected postoperative course? YES NO

--If you have had previous surgery, did any medications make you nauseous? YES NO

if yes, please list them.

-Please list any medications you are currently taking and the reason you are taking them:

-Please list any pain medications which work well for you. (Those that relieve pain and do not make you nauseated):

-Are you allergic to any medications?

YES NO

If yes, describe the medication and the type of reaction:

-Have you ever had an allergy to Latex?

YES NO

-Did you ever have an unusual reaction to anesthesia?

YES NO

Is there a family history of unusual reaction to anesthesia

YES NO

(such as malignant hyperthermia)?

YES NO

-Do you have any of the following medical conditions or any past history of these conditions?

	YES	NO
Arthritis	_____	_____
Asthma or other lung disease	_____	_____
Autoimmune Disease	_____	_____
Bleeding disorder	_____	_____
Chest Pain	_____	_____
Diabetes	_____	_____
Depression	_____	_____
Easy bruising	_____	_____
Heart failure or other heart problems	_____	_____
High Blood Pressure	_____	_____
HIV or other immune deficiency	_____	_____
Lupus	_____	_____
Mitral valve prolapse	_____	_____
Polio	_____	_____
Rheumatic Fever	_____	_____
Scleroderma	_____	_____
Shortness of breath	_____	_____
Substance abuse	_____	_____
Thyroid disease	_____	_____
TMJ (Temporo-Mandibular Joint)	_____	_____
Other Psychiatric Disorders	_____	_____

-What is your: HEIGHT _____ WEIGHT _____

-Do you have any other medical conditions which regularly bring you to a doctor? YES NO
If yes, please list them: _____

-Do you smoke cigarettes or have a history of regular smoking in the past year? YES NO
If yes, how many per day? _____

-Do you drink alcohol? YES NO
If yes, what is the frequency? (number per day, week or month)? _____

-Do you take large doses of any vitamins (especially vitamins A or E)? YES NO

-Have you in the past 12 months taken the drug Acutane or estrogens? YES NO

-Do you have a tendency to form keloids, hypertrophic, thick scars or dark spots around surgical incisions or areas of injury? YES NO

-Do you take aspirin, aspirin-like compounds? (Motrin, Advil, Nuprin, I buprofen, Naprosyn, etc.) or aspirin containing preparations (Bufferin, Anacin, Excedrin, Dristan, Midol, Empirin, Alka Selzer, Fiorinal, Perdocan)? YES NO
If yes, please describe how frequently: _____

-Name of Family Physician or Internist: _____
Date of last visit: _____

-Name of Obstetrician/Gynecologist: _____
Date of last visit: _____

-What is your occupation? _____

-What are your interests and hobbies? _____

To the best of my knowledge the above information is correct. I realize that by giving false information on this questionnaire may adversely affect the care I receive from Dr. Cook.

Signature

Date

Print Name

Date of Birth