John Q. Cook, M.D.

WHOLE BEAUTY

737 N Michigan Ave., Suite 760
Chicago, Il 60611
(312) 751-2112

118 Green Bay Road
Winnetka, Il 60093
(847) 446-7562

PATIENT REGISTRATION AND CONSENT FOR TREATMENT FORM

PATIENT INFORMATION

_____ _____ ☐MALE ☐FEMALE
MR/MRS/MS/DR PREFERRED FIRST NAME

_____ _____ _____
FIRST NAME M.I. LAST NAME

_____ _____
ADDRESS APT.

_____ _____ _____
CITY STATE ZIP

(_____)_____ (_____)_____ _____
HOME PHONE MIOBILE PHONE E-MAIL ADDRESS

_____
BIRTH DATE

☐SINGLE ☐MARRIED ☐OTHER _____

☐ I WOULD LIKE DR. COOK TO KEEP ME INFORMED ABOUT ADVANCES IN PLASTIC SURGERY VIA EMAIL.

DID YOU VISIT OUR WEBSITE AT WWW.JOHQCOOKMD.COM? ☐ YES ☐ NO

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

John Q. Cook, M.D.

WHOLE BEAUTY

EMERGENCY CONTACT

_____ _____

FIRST NAME LAST NAME

_____

RELATIONSHIP

SPOUSE

_____ _____

FIRST NAME LAST NAME

SPOUSE

MEDICAL HISTORY

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 nauseated? _____ ☐ 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):

_____

_____

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-Are you allergic to or have a sensitivity to any medication?_____ ☐ YES ☐ NO

If yes, describe the medication and the type of reaction. Airway obstruction?: _____

-Have you ever been diagnosed with sleep apnea? ☐ YES ☐ NO

-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 a history of nausea from pain medication? ☐ YES ☐ NO

-Do you have any unusual reactions with other medications? ☐ YES ☐ NO

-Do you get lightheaded or faint when giving blood? ☐ YES ☐ NO

-Do you get car sick or motion sickness easily? ☐ YES ☐ NO

-Do you experience lightheadedness after meals? ☐ YES ☐ NO

-Are you apprehensive or nervous about medical procedures? ☐ YES ☐ NO

-Does your dentist have a hard time blocking your nerves for dental procedures,
where multiple injections are required before you feel numb? ☐ YES ☐ NO

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

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YES	**NO**	
____	____	Arthritis
____	____	Asthma or other lung disease
____	____	Pulmonary Embolism
____	____	Autoimmune Disease
____	____	Bleeding disorder
____	____	Blood Clots in Legs
____	____	C.Diff or Antibiotic Associated Diarrhea
____	____	Chest Pain
____	____	Diabetes
____	____	Depression
____	____	Easy bruising
____	____	Heart failure or other heart problems
____	____	High Blood Pressure
____	____	HIV or other immune deficiency
____	____	Low Blood Sugar
____	____	Lupus
____	____	Mitral valve prolapse
____	____	Polio
____	____	Rheumatic Fever
____	____	Scleroderma
____	____	Shortness of breath
____	____	Substance abuse
____	____	Thyroid disease
____	____	TMJ (Temporo-Mandibular Joint)
___	____	Other Psychiatric Disorders

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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, Ibuprofen, Naprosyn, etc.) or aspirin containing preparations_____ ☐ YES ☐ NO
(Bufferin, Anacin, Excedrin, Dristan, Midol, Empirin, Alka Selzer, Fiorinal, Perdocan)?_____ ☐ YES ☐ NO
If yes, please describe how frequently:
_____

-Are you currently on or have been on the human chorionic gonadotropin diet or HCG diet_____ ☐ Yes ☐ No
If you were on this diet..how long ago?
_____

-What is your: HEIGHT_____ WEIGHT_____

-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*

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