John Q. Cook, M.D.

WHOLE BEAUTY®

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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 TO SUBSCRIBE TO DR. COOK¢S BLOG AND NEWSLETTER ABOUT ADVANCES IN PLASTIC SURGERY

☐ I WOULD LIKE TO RECEIVE UPDATES ON TREATMENT AND PRODUCT PROMOTIONS AT THE WHOLE BEAUTY INSITITUTE

DID YOU VISIT OUR WEBSITE AT WWW.JOHNQCOOKMD.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

EMERGENCY CONTACT

FIRST NAME LAST NAME

RELATIONSHIP

(__________)____________________________
MOBILE PHONE

E-MAIL ADDRESS

SPOUSE

FIRST NAME LAST NAME

SPOUSE$ EMPLOYER

(__________)____________________________
SPOUSE$ MOBILE PHONE

EMPLOYMENT INFORMATION

☐FULL TIME ☐FULL TIME STUDENT ☐RETIRED ☐PART TIME ☐PART TIME STUDENT ☐OTHER

OCCUPATION COMPANY OR SCHOOL

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME NAME OF INSURED

ADDRESS CITY STATE ZIP

(__________)____________________________
PHONE POLICY # GROUP #

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*I authorize **John Q. Cook, MD** to furnish information on conditions he has treated me for to my insurance carrier. I assign to Dr. Cook all payments for medical services rendered by him for me or my dependents. I understand that I am responsible for any amount billed and not covered by my insurance. A photocopy of this authorization and assignment is considered as valid as the original.*

SIGNED (PATIENT OR PARENT IF MINOR) DATE

*I hereby authorize **John Q. Cook, M.D.** to release any information acquired in the course of my examination or treatment.*

SIGNED (PATIENT OR PARENT IF MINOR) DATE

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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?______________________________ Ä YES Ä NO

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

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

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

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

____

____

-Have you ever undergone surgery? ____________________________________ Ä YES Ä 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? ____________________ Ä YES Ä NO

--If you have had previous surgery, did any medications make you nauseated? ______________ Ä YES Ä 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?____ Ä YES Ä NO

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

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

-Have you ever had an allergy to Latex? Ä YES Ä NO

-Did you ever have an unusual reaction to anesthesia? Ä YES Ä NO

-Is there a family history of unusual reaction to anesthesia? Ä YES Ä NO
(such as malignant hyperthermia)? Ä YES Ä NO

-Do you have a history of nausea from pain medication? Ä YES Ä NO

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

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

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

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

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

-Does your dentist have a hard time blocking your nerves for dental procedures,
where multiple injections are required before you feel numb? Ä YES Ä 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? ____________ Ä YES Ä NO
If yes, please list them:

____

____

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

-Do you drink alcohol? ____________ Ä YES Ä 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)? ____________ Ä YES Ä NO

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

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

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

____

-Are you currently on or have been on the human chorionic gonadotropin diet or HCG diet____________ ð Yes ð 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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