FANTASTIC PLASTIC SURGERY & SKIN FITNESS

PATIENT REGISTRATION SHEET

SS#: ___________________ Today's Date: ____________

LAST NAME: ______________________________ FIRST : ____________________ MIDDLE INITIAL : _____

ADDRESS: ____________________________________ CITY:_______________ STATE:____ ZIP:__________

HOME PHONE: ____________________ CELL PH:____________________

Date of Birth:_____________________

E-MAIL ADDRESS____

EMPLOYER: ______________________ EMPLOYER ADDRESS: _________________________________

WORK PH: _________________________

MARITAL STATUS: M S D W SEP

SPOUSE'S NAME: ________________________________ PHONE: _____________________

EMPLOYER: ______________________ EMPLOYER ADDRESS: _________________________________

WORK PH: ___________________________________

Please list the nearest relative or friend, not living with you, that we may contact if we are unable to reach you, or in case of emergency:

NAME: ____ PHONE: _______________________

WHOM MAY WE THANK FOR REFERRING YOU TO FANTASTIC PLASTIC SURGERY & SKIN FITNESS?

REFERRED BY DOCTOR: (name)______________________________________

REFERRED BY HOSPITAL: (name)_____________________________________

REFERRED BY FRIEND/PATIENT (*circle one or both*): (name)____________________________________

OTHER (please specify): ____

MEDICAL HISTORY p. 1 Name: ______________________

Date: _________

<u>CONFIDENTIAL RECORD</u>: Information contained below will be used and disclosed as stated in our "Notice of Privacy Practices". This information will be used by Dr. Mischnick in making decisions concerning your care.

Sex (Circle): M F Your Personal Physician: ______________
Date of Birth: ___________ Current Weight: _________ Current Height: __________
Age: ___________

Do you have, or have you had, any Health Problems? (Fill in blanks or Circle Yes or No where applicable)

<u>ALLERGIES:</u> To Food? __________________________
To Medication? ____

<u>CURRENT MEDICATION</u>: ____
<u>Chronic Illnesses</u>: ____
<u>OPERATIONS</u>: ____
<u>DO YOU HAVE IMPLANTS? (Pacemaker, Breast Implants etc.):</u> ________________________________

Do you smoke? No Yes
Skin Cancer? No Yes
Other Cancer? No Yes
Family History of Cancer? No Yes
Are you pregnant? No Yes Due Date: ________________
Have you had pregnancies? No Yes Number? ______ C-Sections? ___________
Hormonal Problems? No Yes
Thyroid Problems? No Yes
Kidney Problems? No Yes
Gastrointestinal Problems? No Yes
Diabetes? No Yes
Psychological History—acute or chronic Depression? No Yes
Other diagnosis or problem? No Yes
Thrombophlebitis or Blood Clots? No Yes
Stroke? No Yes
Excessive Bleeding? No Yes
Mitral Valve Prolapse? No Yes
Lung or Breathing Difficulties? No Yes
(Asthma or Other)
High Blood Pressure? No Yes
Heart Attack? No Yes
Hepatitis (A or B or C) No Yes
AIDS No Yes
Do you have seizures? No Yes
Migraine Headache? No Yes
Multiple Sclerosis or other Neurological Problems? No Yes
Do you have Arthritis ? No Yes
Do you take Anti-inflammatories? No Yes Drug: ___________________________
<u>Do you take Blood Thinners (such as coumadin or Plavix medication)</u>? No Yes

Medical History p. 2 **Name: ____________________________**
Date: _______________

Have you previously undergone any cosmetic surgery (e.g. liposuctions, breast reduction or augmentation, nose operation, scar revision, face lift, collagen for lips, etc)? _____________

Have you had non-surgical dental work (e.g. braces, teeth whitening)? ___________________

Have you ever tried ointments or medications (for skin conditions or baldness)? ________________

Have you ever had a hair transplant? ____________

Have you had operations to reduce weight (e.g. stomach stapling or bypass)? _____________

If you answered yes to any of the questions above, please list the surgeries/remedies tried, how many times tried, and dates.
____

Have you ever been dissatisfied with previous surgery or treatment? _________
Please explain: ____

Signature: _______________________________
Date: __________________

Name: ______________________________ **Date:** ___________

Lifestyle Questions:

Do You Exercise Regularly? No Yes

Do you drink coffee? No Yes

Do You Wear Contact Lenses? No Yes

Are You Currently Under a Lot of Stress? No Yes

Do you drink Alcohol? No Yes

Do you take Vitamin Supplements? No Yes

Do you take Birth Control Pills? No Yes

Are you or have you been on Accutane No Yes

How much time do you spend each day thinking about your appearance? _____________

Do you spend a total of at least an hour or more managing your appearance in front of a mirror each day? _____________

Have your appearance concerns limited your life in any way? Examples: are there situations that you tend to avoid because of how you look, such as your work, school, or social events? _____________

Have family and friends expressed concern over how your appearance preoccupations influence your relationships with them? ______________

Have your appearance concerns caused you stress or emotional pain? ________________

Would you like to gain additional knowledge and coping skills in order to successfully deal with your body image concerns? ______________

Would you like to talk to someone who has dealt with patients who have had the same pre-surgery concerns? _______________

Have You Ever Had an Adverse Reaction to a Cosmetic Product? No Yes

Product Name? _______________________________

Do You Use any Topical Meds? No Yes List: _____________________

Do You Use Retin A ? No Yes

Do You Use Alpha-Hydroxy Acids? No Yes

What Are You Currently Using to Cleanse Your Face? _____________________________

What Are You Currently Using to Moisturize? ______________________________

Special Treatments? (Eye Crème, Night Crème, Masks) ______________________________

What Improvements Would You Like to See ON Your Skin?

____

SIGNATURE: _______________________________ Date: ___________

FANTASTIC PLASTIC SURGERY
CONSENTS/AUTHORIZATIONS

Name:_________________________________ Date of birth:___________

CONSENT TO TREATMENT

I hereby consent to medical treatment rendered by Fantastic Plastic Surgery.

______________ ____________________________________
Date Signature (Patient or Parent if Minor)

CONSENT FOR PHOTOGRAPHY

Pre-treatment and post-treatment photographs are recommended to follow your medical care. Pre-treatment and post-treatment photos may be viewed for educational purposes by our physician or patients. Educational purposes may include: use in physician consults with individual patients or use in physician seminars presented to potential patients or for medical associations or for our web site; or on request, sent to your insurance company.
This consent will be in effect until physician discontinues use of these photographs.
It is our intention to handle all photographs with the highest regard for confidentiality and respect for the patient.

______________ ____________________________________
Date Signature (Patient or Parent if Minor)

PRIVACY NOTICE

I acknowledge that I have received a copy of Fantastic Plastic Surgery & Skin Fitness's Notice of Privacy Practices.

______________ ____________________________________
Date Signature (Patient or Parent if Minor)