COLUMBIA AESTHETIC PLASTIC SURGERY LLC

Restoring Beauty, Restoring Health

Patient Registration

Prefix ________ Name ____

Nickname (if any) __________________ Personal Physician ___________________

How did you hear about our office?

- ☐ Referred by Physician. Which? ____
- ☐ Referred by Friend. Whom? ____
- ☐ Newspaper or Magazine. Which? ____
- ☐ Web Site. How did you find our site? ____
- ☐ Phone Book. Which? ____
- ☐ Other ____

Personal Information

Address ____

City, State, Zip ____

Social Security No ________ - _______ - _________ Birthdate ______/_______/______

Home Phone ____________________ Work Phone _____________________________

Cell Phone _______________________________ (for office use only)

Email Address ____________________________ (for office use only)

Are you? ☐ Married ☐ Single ☐ Divorced/Separated ☐ Widowed

Gender ☐ Male ☐ Female

Spouse's Name (if Married) ____

Spouse's Employer ________________________ Home Phone ______________________

Work Phone ______________________________ Cell Phone _______________________

Are you? ☐ Retired ☐ Student

Occupation _________________________ Company Name ________________________

In Case of Emergency, Please Contact ____

Relationship ______________ *Phone Numbers* __________________________________

Insurance Information (Please inform us if you have **secondary insurance** as well)

Name of Insured _______________________________ Relationship __________________

Employer ____

DOB of Insured ______/______/_____ Social Security No ________ - _______ - ________

Insurance Company _________________________

Policy No ____________________________________ Group No _____________________

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Patient Health History

To help us provide you with optimal health care, please take the time to accurately complete this form. Please note your answers are strictly confidential. Thank you very much.

Name ________________________________ Occupation ___________________

Age _______ Height _________ Weight ______ Are you actively dieting? ❑YES ❑NO

Reason for your visit today? ____

List your Significant Medical Problems ____

____

____

List your Previous Operations (including Cosmetic Procedures).

Operation Year

____

____

____

Are you **Allergic** to any Medications? What happened when you took these medications ?

(include reactions to tape, iodine, local anesthetics, etc.) ___________________________

____

Are you currently on any Medications? (include over-the-counter meds & **supplements**)

Medication	Dose	Frequency

Do you take Aspirin, Motrin, or any Blood thinners on a regular basis? ❑ YES ❑ NO
If YES, what for? ____

Have you been on steroids (Cortisone/Prednisone) in the last year? ❑ YES ❑ NO
If YES, what for? ____

Are you a smoker? ❑YES ❑NO How much do you smoke or when did you Quit?________

How much do you drink? ❑Never ❑Occasionally ❑Nightly (1-2 drinks) ❑Frequently

Have you ever used recreational drugs? ❑YES ❑NO If YES, which? ______________

(**For Women Only**) Are you pregnant? ❑YES ❑NO Are you breastfeeding? ❑YES ❑NO

Are you under the care of a Psychiatrist or Psychologist? ❑YES ❑NO
If YES, what for? ____

Are there any Cancers that run in your family? ❑YES ❑NO
If YES, please explain. ____

Is there a History of Heart Problems, Strokes, or Blood Clots in the Family? ❑YES ❑NO
If YES, please explain. ____

Are there any other serious Medical Conditions that run in the Family? ❑YES ❑NO

If YES, please explain. ____

Have you ever had Skin Cancer? ❑YES ❑NO

If YES, please explain. ____

Do you have a history of any of the following conditions?

Condition	YES	NO	If YES, please explain
Heart Murmur/Damaged Heart Valves?			
Do you take Antibiotics prior to dental work?			
High Blood Pressure?			
Low Blood Pressure?			
Chest Pain/Angina?			
Heart Attack or Stroke?			
Irregular Heart Beat or Pacemaker?			
Asthma or Lung Disease?			
Tuberculosis?			
Shortness of Breath with Walking?			
Pain in the calves with Walking?			
Anemia or Blood Disorders?			
Bleeding Problems (Do you bruise easily)?			
Clotting Problems (DVT,Pulmonary Embolus)?			
Hepatitis or HIV?			
Liver or Kidney Disease?			
Seizures or Epilepsy?			
Thyroid Problems?			
Diabetes?			
Stomach Ulcers?			
Fever blisters of the lips or Herpes?			
Immune system or healing problems?			
Mental Health Problems?			
Glaucoma or Eye disease?			
Dry eyes?			
Do you wear Contact Lenses?			
Radiation Therapy or Chemotherapy?			
Blood transfusion?			
Family history of Malignant Hyperthermia?			
Do you form large scars or keloids?			

Is there any other information that you would like to share that may be helpful in your care?

____

The above information is true to the best of my knowledge. I will not hold my surgeon or his
office responsible for any errors or omissions that I may have made in completion of this form.

Signature ______________________________ **Date** ___________

(FOR OFFICE USE ONLY) ❑ The above patient health history including past medical/surgical history, medications, allergies, family and social history and review of systems has been reviewed with the patient.

______________________________________ E. Chang MD