MORGAN
COSMETIC SURGERY

Registration and Medical History (1/5)

Your contact information and medical history are important.
If some information is too private to write down, mention it to Dr. Morgan. It will not go in your chart.

REGISTRATION

Date:_____Name_____
Title, e.g. Mrs, Ms, Miss, Mr, Dr, Ambassador, etc:_____

How do you wish to be addressed by our staff?_____

Address:_____
_____

Phone #: Cell_____ Home_____ Work_____
At which number(s) may we call you or leave a message? Work: Y/N Home: Y/N Cell: Y/N

Email: _____ Send emails on specials & events? Y / N

Emergency Contact: (name/address/phone numbers for family member or friend to contact if needed)
_____
_____

Primary Care Physician: (name, address, phone of your primary care or other current physicians if any)
_____
_____

Referral: (name of website, advertisement, physician, family member, friend, etc.)
_____
_____

May we let them know you have seen us? Y/N

Please write the name and relationship to you of anyone with whom we may disclose details of your care, e.g. to fill prescriptions, give instructions, answer questions:
First and Last Name: _____ Relationship: _____
Please list what information they may have access to: _____
_____

"I hereby consent to the above person having access to the above listed information."

Patient Name: _____ Patient Signature: _____ Date: _____

Registration and Medical History (2/5)

Date:_____ Initials_____

Height_____ Weight_____ Birthdate_____

Reason for your visit

_____

_____

_____

Do you wear glasses? Y/N Contacts Y/N Date of last eye exam_____

Circle reason for glasses: Reading Driving Astigmatism Other_____

Allergies and Reactions: List *all* bad effects from a food or drug, and what it did. Swelling, hives and skin rashes are especially important:

_____

_____

Smoker? Y/N How many/day_____ Past smoker? Y/N When did you stop?_____

Caffeine? Y/N How much on an average day_____ Or an average week_____

Alcohol? Y/N How much on an average day_____ Or an average week_____

Exercise: Y/N How much on an average day_____ Or an average week_____

Work: Y/N How much in an average day_____ Or an average week_____

Prednisone or other steroids: When, what dose, reason:

_____

Please list **all prescription medicines, doses and reason for taking the medicine**:

_____

_____

_____

Please list all non-**prescription medicines, herbals and supplements, doses and reason for taking them:**

_____

_____

Do you take **recreational drugs**: Y/N If yes, what?: _____

Registration and Medical History (3/5)

Date:_____ Initials_____

Please list, starting with childhood, the year and type of each significant medical illness, diagnosis, operation or event, including car accidents, illness when abroad.

Please include current symptoms that bother you, even if there is no diagnosis:

_____
_____
_____
_____
_____
_____
_____
_____

If over 50 or have history of heart problems: When was your last EKG? _____

Result?_____ **An EKG w/in 1 month is needed for all patients over 50 or with heart problems before surgery. Cardiology clearance required for abnormal EKG.**

Do you have a **chronic cough?** Y/N **wheezing?** Y/N **COPD?** Y/N **asthma?** Y/N

Can you **walk up a flight of stairs,** not stopping? Y/N Can you **walk 3 miles in an hour**? Y/N

Have you ever needed **emergency care for trouble breathing** for any reason? Y/N

Can you **run to catch a bus**? Y/N Can you **do heavy housework**? Y/N

Circle any that apply: bleeding episodes easy bruising transfusions
chronic pain Hepatitis kidney disease diabetes
cancer other malignancy

Do you take blood thinners? Y/N Heart medicines? Y/N

Have you taken diet pills? Y/N If so, what and when _____

Do you snore, wake repeatedly at night or stop breathing during the night? Y/N

Do you have heart disease? Y/N Low thyroid? Y/N High Thyroid? Y/N

If you have had previous surgery, have you had problems, e.g. with anesthesia, breathing, hyperthermia, bleeding, infection or poor results?

_____

Have you been treated for cancer? If so, what kind of cancer and treatment?

_____

Are you **more sensitive to pain or to medicines** than most people? If so, what helps?

_____

If "no stress" is 0 and "maximum stress" is 10, how would you rate your **stress** in the past 12 months? _____

Is stress getting worse, better, the same? _____

How would you rate your general health from 0-10, if 10 is perfect? _____

Please list **major medical problems of relatives**, alive and deceased, including cancer, bleeding, trouble with anesthesia, heart disease, blood clots, etc.

_____
_____

Registration and Medical History (4/5)

Date:_____ Initials_____

CIRCLE ANY THAT APPLY TO YOU – if you didn't include them on Page 3.

Headaches	Burns	Jaundice	Sleep Apnea
Seizure	Severe sunburn	Hepatitis	Reflux
Stroke	Acne	Gallstones	Back pain
Depression/Insomnia	Skin cancer	Pancreatitis	Deviated septum
Anxiety	Dermatitis	Kidney stones	Sinus infections
Deafness	Shortness of breath	Bladder infections	Stroke
Blindness	Nose bleeds	Kidney infections	Snoring/sleep apnea
Glaucoma	Nose allergies	Kidney failure	Heart attack
Near vision	Strep throat	Transfusions	Aneurysm
Dizziness	Chronic cough	Trouble sleeping	Giardia
Nerve injury	Trouble swallowing	Bleeding/bruising	West Nile Virus
Post-traumatic stress	Asthma	Hair thinning	Temporal arteritis
Infections	Pneumonia	Low platelets	Polymyalgia
Herpes	Emphysema	Concussion	Fibromyalgia
Hives	COPD	Bell's Palsy	Fractures
Ulcerative colitis	Bronchitis	Blood clots	Tumors, benign
Crohn's	Wheezing	Rheumatoid arthritis	Tumors, malignant
Raynaud's	Heart/chest pain	Rheumatic fever	Ulcers Ascites
Sjogren's	High cholesterol	Bloating	Bloating
Dry eye	Diabetes	Poor circulation	Swelling
Extreme fatigue	High Thyroid	Heart attack	Bleeding
Night sweats	Low thyroid	Heart murmur	Diarrhea
Hashimoto's	High blood pressure	Lyme Disease	Trouble urinating
Auto-immune disease	Varicose veins	Heart failure	Trouble passing stool
Cold sores	Aching legs	Neck pain	Change in bowel/bladder function
Psoriasis	Stomach ulcers	Shoulder pain	

Have you had stomach pain, diarrhea, jaundice, severe headache, personality change or extreme fatigue from any medicine – not described above – including:

Reglan Levaquin Metronidazole (Flagyl) Tindamax Tylenol
Keflex Cipro Monistat Hormones Compazine
Other_____

For women: Pregnancies_____ Children_____ Last menses _____ Menopause_____
In any pregnancy, did you have toxemia, premature baby or other issues? Y/N_____
Breast Surgery Y/N _____ Breast biopsy Y/N_____
Last mammogram_____ Was it normal? Y/N
Do you have breast implants? Y/N Any chest pain since surgery? Y/N_____
Any chance that you are pregnant or might be before surgery? Y/N _____

Registration and Medical History (5/5)

Date:_____ Initials_____

Any other health issues or concerns? _____

Please sign and date:
Signature_____Date_____

Optional – To help you as much as we can, it sometimes helps if we get to know you more.
Remember - every question below is optional.
Marital status. _____
Children's names and ages: _____
Hobbies _____
Recent travel or planned trips_____

Do you have any cosmetic questions not covered by plastic surgery, e.g. hair care, teeth? We would be happy to refer you.

_____

Would you like information about something besides what brings you to see us today? Below are common issues for new patients. Just circle any that apply.

Skin care advice	Smile lines	Neck wrinkles
Skin care products	Mouth 'parentheses'	Sun damage
Injectables	Brown or age spots, freckles	Make-up
Botox/Juvederm	Drooping brow	Facial contouring
Fine lines/wrinkles of face	Length/fullness of lashes	Facial Redness
Thin lips	Facial Fullness	Unwanted hair
Forehead wrinkles	Mole removal	Dark circles under eyes
Frown lines	Scar revision	Eye puffiness
Crow's feet	Excess sweating	Anything else – note below

_____

_____

_____

Thank you,

Dr. Morgan and her staff