| Date: | REGISTRATION | MR #: |
|---|---|---|

Last Name: First Name: M.I.: Nickname:

Home Phone: Work Phone: Cell Phone: Other Phone:

Home Address:

City: State: Zip:

Employer:

Work Address:

City: State: Zip:

Occupation: Circle One: Single Married Widowed Separated Divorced

Age: Date of Birth: Soc. Sec. # Driver's License # and State:

In case of emergency, who should be notified? Phone:

## Medical Information

*Please LIST ALL medications you have taken in the past year, including over-the-counter, vitamin and herbal products. CIRCLE all medications you are currently taking:*

______________________________________________

ARE YOU ALLERGIC TO ANY MEDICATIONS OR FOODS? IF YES, PLEASE LIST:______________________________

*Have you ever had any injections for cosmetic purposes?* ☐ *NO* ☐ *YES If YES, please list:* ______________________________

*Have you ever had:*

| | YES | NO | | | YES | NO |
|---|---|---|---|---|---|---|
| Accutane | | | | Do you use any Retin-A products? | | |
| Cold sore of the lip | | | | Do you use alpha-hydroxy or glycol based products? | | |
| Facial nerve weakness, Bell's Palsy, eye conditions or neurological conditions? | | | | Are you on aspirin, Motrin, ibuprofen, Naprosyn, or other similar anti-inflammatory medications? | | |
| Skin infections / Disorders | | | | Are you ALLERGIC to latex or rubber? | | |
| Diabetes | | | | Have you used self-tanning or spray tan in the past 2 months? | | |
| HIV+ / AIDS | | | | Have you used a tanning salon in the past 2 months? | | |
| Keloids | | | | Do you take any blood thinners like Coumadin or Plavix? | | |
| Rosacea | | | | Have you had vitiligo or loss of skin pigment? | | |
| Hepatitis | | | | Have you had facial warts? | | |
| Tattoos / Permanent Makeup | | | | Are you allergic to salicylates (ex. aspirin)? | | |
| Skin Cancer | | | | Do you have a pacemaker or cardiac rhythm problem? | | |

**** For Women Only****

*I am not pregnant or breast feeding and I fully consent to any therapies that would be considered unsafe during pregnancy or breast feeding.*

X______________________________

*I verify that the information of this registration form is true and accurate to the best of my knowledge.*

X______________________________ *Date* ______________________
*Signature of Client (or parent, if minor)*

X______________________________
*Relationship (if signing for minor)*

## Surgery Consultation Addendum

*Please list ALL previous surgeries (include all cosmetic procedures and those from childhood):*

______________________________________________________________________________

______________________________________________________________________________

*Have you ever been hospitalized for any reason other than surgery? If so, please describe:*

*When was your last medical exam?* *With whom?*

*Who is your primary care physician?* Name:

Address:

Telephone:

*Do any illnesses run in the family?* ☐ NO ☐ YES → If YES, which?

*For Women only:*

No. of Pregnancies ________ Live births ________ Date of last mammogram ___________________ Last menstrual period ___________________

| | YES | NO |
|---|---|---|
| Have you had any problems with anesthesia before? | | |
| Have you taken any steroid medication within the past 12 months? | | |
| Have you had any problems with scars or healing of your skin? | | |
| Do you take diet pills or drinks? | | |
| Do you use “recreational” drugs (ex. cocaine, marijuana, etc.)? *This information is confidential.* | | |
| Have you ever had blood clots in your legs? | | |
| Have you ever received chemotherapy? | | |
| Have you ever received radiation therapy? | | |
| Have you been seen or treated by a psychiatrist or psychologist? | | |

*Please CIRCLE all conditions that you have had:*

| | | | | |
|---|---|---|---|---|
| EASY BRUISING | HEPATITIS | HEART DISEASE | ASTHMA | HIGH BLOOD PRESSURE |
| ANEMIA | TUBERCULOSIS | THYROID DISEASE | STOMACH ULCER | MITRAL VALVE PROLAPSE |
| ARTHRITIS | RHEUMATIC FEVER | EYE DISEASES | HIV+ / AIDS | BLEEDING TENDENCY |
| STROKE | KIDNEY DISEASE | DEPRESSION | CANCER | BLOOD TRANSFUSIONS |
| | | WEIGHT CHANGE | | RAPID HEART RATE |

*Do you smoke?* ☐ NO ☐ YES → If YES, what kind and how much per day? ________________________________________

If you are a former smoker, when did you quit? ________________________________________

*Do you drink alcohol?* ☐ NO ☐ YES → If YES, what kind and how much per week? ________________________________________

*I verify that the information of this registration form is true and accurate to the best of my knowledge.*

*X*____________________________________________ *Date* ____________________________

*Signature of Client (or parent, if minor)*

*X*____________________________________________

*Relationship (if signing for minor)*