BOSTON CENTER FOR PLASTIC SURGERY

Leonard Miller M.D., FACS, FRCS ● Sean Doherty, M.D., FACS

Akshay Sanan, M.D., FACS ● Vickram Tandon, MD ● Melissa Michelon, M.D.

PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Age: _____ Marital Status _____ Sex: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Which number do you prefer to be contacted on? Home ☐ Cell ☐ Can we send communication via text? _____

E-mail address: _____ Pharmacy name, address & phone: _____

EMPLOYMENT

Occupation: _____ Employer: _____

Address: _____

City: _____ State: _____ Zip Code: _____

REFERRED BY

Name: _____ Relationship: _____

Address _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Emergency Contact

Name: _____ Relationship: _____

Address _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

PRIMARY CARE PHYSICIAN

Name: _____ Phone: ( ) _____

Address _____

City: _____ State: _____ Zip Code: _____

THE FOLLOWING AGREEMENT MUST BE SIGNED BY ALL PATIENTS AND/OR GUARDIANS:
I assume full responsibility for, and agree to prompt and full payment of, all charges incurred by me (or person for whom I am legally responsible).

Signature : _____ **Today's Date:** _____

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HEALTH HISTORY

Name:_____ Height:_____ Weight: _____

Purpose of visit/ procedure: _____

In addition to this consultation, are there any other procedures or treatments that would interest you? ☐ Yes ☐ No

Please explain: _____

List operations in the past: _____

Do you have any allergies to any medications, food etc.? _____

_____

What type of symptoms have you experienced? _____

Do you have any allergies to anesthesia? ☐ Yes ☐ No If yes please explain: _____

Please list additional drugs/items that cause allergic reactions: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Are you currently being treated for a medical condition? ☐ Yes ☐ No

If yes please explain _____

Have you seen other plastic surgeons for the problem which brings you here today? ☐ Yes ☐ No

Do you presently or have you ever experienced the following? Please check all that apply

☐ Abnormal Bleeding	☐ Congenital Heart Defect	☐ Hay Fever	☐ Liver Problems	☐ Radiation Treatment
☐ Anemia	☐ Diabetes	☐ Heart Trouble	☐ Low Blood Pressure	☐ Shingles
☐ Acid Reflux	☐ Emphysema	☐ Hemophilia	☐ Lupus	☐ Sickle Disease
☐ Arthritis	☐ Epilepsy	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Sinus Problems
☐ Asthma	☐ Fainting Spells	☐ Herpes	☐ Pacemaker	☐ Thyroid Problems
☐ Cancer	☐ Fever Blisters	☐ High Blood Pressure		☐ Tuberculosis
☐ Chemotherapy	☐ Glaucoma	☐ Kidney Problems		☐ Ulcers

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Do you take aspirin? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Do you bleed easily from cuts of surgery? ☐ Yes ☐ No

Do you form large scars or keloids? ☐ Yes ☐ No

Do you have frequent boils or infections? ☐ Yes ☐ No

Have you ever had previous cosmetic surgery? ☐ Yes ☐ No

Do you take anti-inflammatory drugs such as: Ibuprofen, Advil, Aleve, etc.: ☐ Yes ☐ No

Please explain any other serious medical condition(s) that you have experienced: _____

Medications: List all medications you are taking (including non-prescription):

	Name	Dosage	How Often Taken
1.			
2.			
3.			
4.			

For women if applicable only:

If applicable to this visit, please state bra size: _____ # of pregnancies _____ # of children delivered _____

Are you pregnant? ☐ Yes ☐ No ☐ Unsure When was the date of your last mammogram? _____

List any form of cancer – breast, cervical, ovarian, other: _____

You cannot have surgery if you are pregnant

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FACIAL REJUVENATION QUESTIONNAIRE

WHAT ARE YOUR CONCERNS? (PLEASE CHECK ALL THAT APPLY)

___ Frown lines between the brows
___ Significant lines around nose and mouth
___ Sunken cheeks
___ Facial hair
___ Acne
___ Freckles and age spots
___ Fine lines and wrinkles
___ Rough sun damaged skin texture
___ Sagging skin (face and neck)
___ Hyperpigmentation
___ Dark Circles under eyes
___ Dry skin
___ Jowls
___ Lips
___ Pores
___ Eyelashes
___ Facial Veins

ARE YOU INTERESTED IN LEARNING MORE ABOUT THE FOLLOWING?

___ Botox© cosmetic
___ Injectable fillers
___ Skin care advice
___ Skin care products
___ Hair removal
___ Eyelash growth products
___ Chemical Peels (TCA)
___ Facial and eye treatments
___ Laser skin resurfacing
___ Laser treatments
___ Spider vein treatment
___ Acne treatments
___ Retin A
___ Renova
___ Vitamin creams
___ Skin rejuvenation
___ Sun protection

Other, please specify _____

ARE YOU INTERESTED IN METTING ONE OF OUR COSMETIC SKIN CARE CONSULTANTS IN ORDER TO CREATE A PERSONAL TREATMENT PLAN DESIGNED TO MEET YOUR COSMETIC NEEDS?

___ Yes ___ No

WHEN LOOKING AT MY FACE IN THE MIRROR, I BELIEVE I LOOK YOUNGER, THE SAME AS, OR OLDER THAN MY TRUE AGE

Younger than		True age		Older than
1	2	3	4	5

WHEN LOOKING IN THE MIRROR, I AM NOT CONCERNED, SOMEWHAT CONCERNED, OR VERY CONCERNED ABOUT THE APPEARANCE OF MY WRINKLES

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5