Chicago Plastic Surgery Center, LLC
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Facial Plastic and Reconstructive Surgery
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PATIENT REGISTRATION INFORMATION

Patients Name:_____ _____ _____
First Middle Initial Last

Address(Home):_____
Street Apt. Number City State Zip code

Home Phone: _____ **Cell**_____ **E-Mail**_____

Date of Birth: _____

Family Physician:_____

Referred by:_____

Employer:_____ **Work Phone:**_____

Occupation_____ **Business Address**_____

For what reasons are you seeking consultation today? _____

_____

OPERATIONS:

What cosmetic procedures, if any, have you had? _____
What other operations have you had? _____
Were there any complications? _____

ALLERGIES:

Are you allergic to any medications? If yes, list drug and reaction type.

_____

_____

Are you allergic to tape? (band-aids) _____

MEDICATIONS:

What medications are you presently taking and what are the dosages? _____
Do you take aspirin or medications that contain aspirin? _____
Have you taken any steroid preparations in the past year? _____
Do you use inhalers or nasal sprays? _____

MEDICAL HISTORY:

Height_____ Weight_____
How is your general health? _____
Have you had any significant weight changes over the past ten years? _____
If yes, how much gain or loss over how long a period of time? _____
Are you presently being treated for any medical condition? _____
If yes, what condition? _____
When was your last physical examination? _____

REVIEW OF SYSTEMS

(Please check one)

Face & Neck:	YES	NO
Irradiation to the face or neck?	_____	_____
Facial paralysis or weakness?	_____	_____
Skin problems (acne cancers, etc.)	_____	_____
If yes, which problems? _____		
_____		
Thyroid disease?	_____	_____
Do you wear dentures?	_____	_____

EYES:	YES	NO
Visual loss? (one or both eyes)	_____	_____
Dry or scratchy eyes?	_____	_____
Blurred or double vision?	_____	_____
Crossed or lazy eyes?	_____	_____
Corneal problems?	_____	_____
Glaucoma?	_____	_____
Cataracts?	_____	_____
Do you wear contacts or glasses?	_____	_____

NOSE:	YES	NO
Difficulty breathing through nose?	_____	_____
Previous injury or fracture to nose?	_____	_____
Nasal allergies?	_____	_____
Nose bleeds?	_____	_____
Sinus conditions?	_____	_____

CARDIOVASCULAR:	YES	NO
Chest pain?	_____	_____
Heart Attack?	_____	_____
Congenital heart disease?	_____	_____
Rheumatic fever in past?	_____	_____
Heart Murmur?	_____	_____
Do you take prophylaxis?	_____	_____
Palpitations or irregular heart beat?	_____	_____
High blood pressure?	_____	_____
Stroke?	_____	_____
Mitral valve prolapse?	_____	_____
Heart failure?	_____	_____
Other?	_____	_____

CHEST:	YES	NO
Shortness of breath?	_____	_____
Chronic lung disease?	_____	_____
Chronic cough?	_____	_____
Asthma?	_____	_____
Breast tumors or disease?	_____	_____

OTHER:	YES	NO
Tumors?	_____	_____
Previous blood clots?	_____	_____
Bleeding disorders?	_____	_____
Do you bruise easily?	_____	_____
Anemia?	_____	_____
Blood transfusion?	_____	_____
If yes, when? _____		
Blood in urine or stool?	_____	_____
Liver disorder including, hepatitis or cirrhosis?	_____	_____
Abdominal pain or ulcer?	_____	_____
Kidney or bladder problems?	_____	_____
Spinal or back disorders?	_____	_____
Diabetes?	_____	_____
Autoimmune diseases? (lupus, rheumatoid arthritis, etc.)	_____	_____
Osteoarthritis?	_____	_____
Headaches or migraines?	_____	_____
Blackouts or epilepsy?	_____	_____
Paralysis or nerve disorder?	_____	_____
Thick scars or keloids?	_____	_____
AIDS or Aids related diseases?	_____	_____
If female, are you pregnant?	_____	_____

PSYCHIATRIC:	YES	NO
Have you ever received psychiatric treatment?	_____	_____
If yes, were you hospitalized?	_____	_____
Has there been any recent crisis in your life?	_____	_____

SOCIAL HISTORY:

	YES	NO
Are you married?	_____	_____
How many children do you have? (____)		
If you are not married, are you Divorced ____		
Widowed ____		
Always single ____		
Do you live alone?	_____	_____
Is there someone who can help you after surgery if needed?	_____	_____
Do you, have you ever smoked?	_____	_____
If yes, number of packs per day (_____)		
Do you drink alcoholic beverages?	_____	_____
Daily?	_____	_____
Occasionally?	_____	_____
Have you ever taken addicting or recreational drugs?	_____	_____

ASTHETIC SURGERY:

If you are considering cosmetic surgery….
Why do you want surgery?_____
_____
What do you think cosmetic surgery will do for you?_____
_____
How long have you been considering cosmetic surgery? _____
_____
Have you discussed surgery with friends, family or other physicians? _____
If yes are they supportive or trying to dissuade you from surgery? _____
My time frame for surgery is:

_____ as soon as possible
_____ 1-3 months from now
_____ 4-6 months from now
_____ 7-12 months from now
_____ Undecided

List below any specific questions you would like to have answered during your consultation:

_____
_____
_____
_____

Print name: _____Signature: _____Date_____

Stacie D. McClane M.D. _____ Date _____