



PACIFIC AESTHETIC INSTITUTE

New Patient Registration

Today's Date:		Social Security Number:	
Name: <i>Last</i>	<i>First</i>	<i>Middle</i>	
How do you like to be addressed:		Date of Birth:	
Address: <i>Street</i>			
<i>City</i>	<i>State</i>	<i>Zip</i>	
Email Address:			
Preferred Contact Number: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<i>Cell Phone:</i>	
<i>Home Phone:</i>		<i>Work Phone:</i>	

Reason for today's visit: <input type="checkbox"/> Botox <input type="checkbox"/> Fillers <input type="checkbox"/> Facials <input type="checkbox"/> Skincare <input type="checkbox"/> IPL/Lasers <input type="checkbox"/> Surgical Consultation
<input type="checkbox"/> Other
If surgical consultation, for what procedure?
How did you hear about us? <input type="checkbox"/> Friend <input type="checkbox"/> Physician <input type="checkbox"/> Internet <input type="checkbox"/> Radio <input type="checkbox"/> Print Media
If you were referred by a person, who may be thank for the referral?
Name: <i>Last</i> <i>First</i> <i>Middle</i>

Please provide a copy of your driver's license for our records.

Medical History Form

How is your general health? Good Average Poor Most recent physical examination? _____

Current Medical Problems:

Anemia	<input type="checkbox"/> Y	<input type="checkbox"/> N	Depression	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hypothyroidism	<input type="checkbox"/> Y	<input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Kidney Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Mitral Valve Prolapse	<input type="checkbox"/> Y	<input type="checkbox"/> N
AIDS/HIV	<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Rheumatic Fever	<input type="checkbox"/> Y	<input type="checkbox"/> N
Bleeding Disorder	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hepatitis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Stomach Ulcer	<input type="checkbox"/> Y	<input type="checkbox"/> N
Breast Cancer	<input type="checkbox"/> Y	<input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y	<input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hyper-thyroidsim	<input type="checkbox"/> Y	<input type="checkbox"/> N			

Other: _____

Previous Surgeries: (Type/Date/Surgeon/Complications or difficulties)

Previous Plastic Surgeries: (Type/Date/Surgeon/Complications or difficulties)

Family History of Medical Problems:

Anemia	<input type="checkbox"/> Y	<input type="checkbox"/> N	Depression	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hypothyroidism	<input type="checkbox"/> Y	<input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Kidney Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Mitral Valve Prolapse	<input type="checkbox"/> Y	<input type="checkbox"/> N
AIDS/HIV	<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Rheumatic Fever	<input type="checkbox"/> Y	<input type="checkbox"/> N
Bleeding Disorder	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hepatitis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Stomach Ulcer	<input type="checkbox"/> Y	<input type="checkbox"/> N
Breast Cancer	<input type="checkbox"/> Y	<input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y	<input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hyperthyroidsim	<input type="checkbox"/> Y	<input type="checkbox"/> N			

Other: _____

Do you smoke? Yes No How many packs per day? _____ How many years? _____

Do you drink alcoholic beverages? Yes No **If yes:** Infrequently Socially Frequently

Do you use recreational drugs? Yes No

Do you have a bleeding disorder or bleed easily? Yes No

Do you have any Drug Allergies: Yes No If yes, please list medication and reaction to medication:

Current Medications (including vitamins, herbal, and non-prescription medications):

Female Breast Health History Form

At what age did your menstrual cycles begin? _____

If you no longer have menstrual cycles, what age did you reach menopause? _____

Do you have any family members who had breast cancer? Yes No

If yes, what was their relationship to you? _____

Do you perform regular breast self exams? Yes No

If you perform routine BSE's, do you have any of the following:

abnormal nipple discharge breast lumps

When your last mammogram? Never had one I have, the last one was on _____

Were the results normal? Yes No

(For Breast Reduction Patients Only)

What is your height? _____ What is your current weight? _____

What is your current bra size? _____ What is your desired breast size? _____

Do you have any of the following symptoms:

Neck pain Shoulder pain Back pain Shoulder grooving Breast pain

Recurrent Rashes under your breasts Postural problems

If you suffer from any of the above symptoms, at what age did you first notice your breasts were excessively large and started causing symptoms? _____

Have these symptoms gotten worse recently? Yes No

If yes, how long ago did it start getting worse? _____

Does anything exacerbate or alleviate these symptoms? Yes No

If yes, what makes these symptoms better? _____

If yes, what makes these symptoms worse? _____

Do you currently wear a good supportive bra? Yes No How long does the bra last? _____

Have you received any treatment for these symptoms? Yes No

If you received treatment for your ailments, which of the following have you undergone?

Physical Therapy Chiropractic Treatments Narcotic Pain Medications

Non-Narcotic Pain Medication Muscle Relaxants Rash Medications

Did you every have radiological studies of your neck/spine? Yes No Were the results normal? Yes No

If the results were abnormal, what were the abnormalities detected?



Notice Of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have a certain right to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessment and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name

Patient's Signature

Relation to Patient

Date