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## Cosmetic Services - Patient Registration

Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last First Middle

Social Security Number: \_\_\_\_\_ Sex:  Female  Male

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_

Marital Status:  Single  Married  Partnered  Divorced  Separated  Widowed  Other

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

E-mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Full Time  Part Time  Self Employed  Homemaker  Student  Disabled  Unemployed

How did you hear about us? \_\_\_\_\_

### EMERGENCY INFORMATION

*In case of an emergency, we would appreciate the name of a contact.*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Last, First, Middle

***Please read the following statement carefully before signing:***

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize the clinic to receive all benefits to which my dependents or I are entitled under my health insurance plan. In addition, I will not withhold or delay payment if my insurance company denies payment on any of the charges. I have been informed of the \$35.00 fee (per RCW 62A.3-515 & 520) on checks returned from my bank for insufficient funds. The undersigned agrees that whether s/he signs as an agent, that s/he is obligated to pay for the account. Should the balance of the account exceed an amount the undersigned agrees to pay in full, a payment plan can be established with 1% per month interest (per RCW 19.52) on the unpaid balance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Please give the receptionist your insurance card.***

# Medical History

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security \_\_\_\_\_

DOB: \_\_\_\_\_ Age \_\_\_\_\_

FOR OFFICE USE ONLY					
Height _____	Weight _____	BMI _____	Neck _____	Goal _____	Ideal _____
BMI>45	Age>38	Apnea	HbA1c _____	Insulin _____	Male _____
Temp _____	HR _____	BP _____	/		

PAST MEDICAL HISTORY
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*Please circle the appropriate response:*

Antibiotics for dental work?    YES    NO    Past or present use of tobacco?    YES    NO

Are you currently under medical care for any reason?    YES    NO    Current use: \_\_\_\_\_ packs/day

If quit, when? \_\_\_\_\_

Problems with anesthesia?    YES    NO    Past or present use of alcohol?    YES    NO

Current use. How often? \_\_\_\_\_

If quit, when? \_\_\_\_\_

PAST COSMETIC TREATMENTS
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Have you had prior treatment with Botox (botulism toxin) or dermal fillers?    YES    NO

If so, when and what areas were treated? \_\_\_\_\_

On a scale of 1 - 10, 10 being very satisfied, rate your results with these treatments: \_\_\_\_\_

Did you have problems with the treatment?    YES    NO

If so, please explain: \_\_\_\_\_

PAST SURGICAL HISTORY		PAST HOSPITALIZATIONS	
Please list all surgeries <i>(include cosmetic procedures)</i>	Approximate date	Please list all hospitalizations	Approximate date

*It is the responsibility of our patients to accurately inform us of any medications, medical history or information possibly relevant to your surgery. Any misinformation, purposeful or otherwise may lead to improper treatment and potentially adverse reactions to proposed medications. Any purposeful misinformation related to the information presented in this record may result in termination of the doctor patient relationship and any care with our organization.*

FOR OFFICE USE ONLY - PATIENT MEDICAL SUMMARY

# Review of Symptoms

Please circle the appropriate response

## GENERAL

Fevers	YES	NO
Sweats	YES	NO
Fatigue	YES	NO
Loss of appetite	YES	NO
Bloody sputum	YES	NO
Persistent cough	YES	NO
Sun/tanning exposure within last month	YES	NO
Any anesthesia problems	YES	NO
Weight stable for 6 months	YES	NO
Weight loss or gain	YES	NO

## SKIN

Keloids	YES	NO
Abnormal pigmentation	YES	NO
Cold sores	YES	NO
Sun hypersensitivity	YES	NO
Rash	YES	NO
Hirsute (excess body hair)	YES	NO
Acne	YES	NO
Skin cancer	YES	NO
Chemical peels	YES	NO
Lupus	YES	NO
Excessive sweating	YES	NO

## SENSES

Visual or eye problems	YES	NO
Hearing problems	YES	NO
Ear ringing	YES	NO

## NEUROLOGICAL

Dizziness	YES	NO
Migraines	YES	NO
Seizures	YES	NO
Strokes	YES	NO
Difficulty with speech	YES	NO
Neuromuscular disorders	YES	NO
Myasthenia gravis	YES	NO
Memory loss	YES	NO
Shaking	YES	NO
Numbness	YES	NO
Coordination problems	YES	NO

## GENITO-URINARY

Urinary tract/kidney problems	YES	NO
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## SLEEP APNEA

Sleep apnea	YES	NO
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## INFECTION

HIV	YES	NO
AIDS contact	YES	NO
TB exposure or the disease	YES	NO
Swollen glands	YES	NO
Recurring infections	YES	NO
Skin infections	YES	NO

## EXERCISE LIMITATIONS

Mild	YES	NO
Moderate	YES	NO
Severe	YES	NO

## PAIN IN JOINTS

Back	YES	NO
Hips	YES	NO
Knees	YES	NO
Feet	YES	NO
Arthritis	YES	NO
Where?	_____	

## GASTROINTESTINAL

Stomach pains	YES	NO
Stomach ulcers	YES	NO
Rectal bleeding	YES	NO
Liver disease	YES	NO
Hepatitis or cirrhosis	YES	NO
Colitis or enteritis	YES	NO
Frequent diarrhea	YES	NO
Frequent constipation	YES	NO
Crohn's disease	YES	NO

## ENDOCRINE

Diabetes currently?	YES	NO
Age of onset:	_____	
Diabetes control	GOOD	POOR
Excessive thirst	YES	NO
Thyroid problems	YES	NO
Problems with glands or hormones	YES	NO

## PULMONARY DISEASE

Short of breath on exertion	YES	NO
Hay fever	YES	NO
Emphysema/COPD	YES	NO
Pneumonia	YES	NO
Asthma/choking	YES	NO
Aspiration/choking	YES	NO

## Review of Symptoms *(continued)*

GYNECOLOGICAL (females only)		
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Last menstrual period: \_\_\_\_\_

Pregnancies: \_\_\_\_\_

Current contraception: \_\_\_\_\_

Currently pregnant? YES    NO

Intend pregnancy next 2 yrs? YES    NO

CARDIOVASCULAR		
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Heart attack	YES	NO
Congestive heart failure	YES	NO
Thrombophlebitis	YES	NO
Swelling of ankles	YES	NO
Chest pain	YES	NO
Coronary heart disease	YES	NO
Varicose veins	YES	NO
Heart murmur	YES	NO
Pulmonary embolism	YES	NO
Stroke	YES	NO
Hypertension	YES	NO

HEMATOLOGIC		
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Bleeding problems	YES	NO
Blood clots in legs or lungs	YES	NO
Anemia	YES	NO

PSYCHOLOGICAL		
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Depression	YES	NO
Feeling down	YES	NO
Suicidal episodes	YES	NO
Mood swings for days at a time	YES	NO
Hospitalized for psych. reasons	YES	NO
Eating disorder	YES	NO
Vomiting to lose weight	YES	NO
Fasting to lose weight	YES	NO
Laxatives to lose weight	YES	NO
Life more stable than 1 yr. ago	YES	NO
History of sexual abuse	YES	NO
Psychiatric medications in past or present	YES	NO



## Social History

Religious preference: \_\_\_\_\_  
Ethnic background: \_\_\_\_\_  
Education: \_\_\_\_\_  
What type of work or hobbies do you do? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Family History

DISEASE	WHICH FAMILY MEMBER HAD IT?	WHEN?	WAS IT FATAL?
Cancer (what type)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Diabetes	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Heart attack	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Other	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____