Paradise Valley Cosmetic Surgery Center

5410 N. Scottsdale Rd., Suite E100
Paradise Valley, AZ 85253
480-994-4080

PATIENT REGISTRATION FORM

LAST NAME: _____

FIRST NAME: _____

ADDRESS: _____

CITY / STATE / ZIP: _____

PHYSICIAN: _____

GENDER: _____ **S.S. #** _____

*** **ALLERGIES:** _____ ***

DATE OF BIRTH: _____ **AGE:** _____

CELL PHONE: _____

HOME PHONE: _____

EMERGENCY CONTACT

NAME: _____

TELEPHONE: _____

RELATIONSHIP TO PATIENT: _____

Paradise Valley Cosmetic Surgery Center

Health History (2 sides)

Name:_____ Age:_____ Height:_____ Weight:_____ Sex:___

Have you ever smoked or use nicotine products? ☐ **Yes** ☐ **No** **How much?**_____ **How long?**___

Are you presently taking any medications? ☐ **Yes** ☐ **No**

Medication Name	Dosage	How often taken?
_____	_____	_____
_____	_____	_____

Are you allergic to any medications? ☐ **Yes** ☐ **No**

List Medication Name and type of allergic reaction experienced:

_____ _____

_____ _____

Are you allergic to: **Soybean** ☐ Yes ☐ No **Eggs** ☐ Yes ☐ No **Latex** ☐ Yes ☐ No

Have you had any surgical operations? ☐ Yes ☐ No

Date of Surgery	**Type of Surgery**
_____	_____
_____	_____

Have you or any blood relatives had unusual reactions or problems with anesthesia?

_____

_____

Have you ever required hospitalization for any serious medical illness? ☐ Yes ☐ No

Date of hospitalization	**Medical Condition Suffered**
_____	_____
_____	_____

Family History: Do you have a family history for any of the following disorders?

Breast Cancer	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Bleeding or Blood disorders	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer:_____	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Tuberculosis (T.B.)	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No		

Additional information, which you feel, should be known before you undergo any type of surgery (i.e. special catheter, no latex, tape allergies).

_____

_____

I have completed all applicable questions on the "Patient Health History." The above facts are true and correct to the best of my knowledge.

_____ _____

Signature of Patient or Responsible Guardian Date

(Over)

Have you ever had any of the following problems?

LUNGS (pulmonary)	Yes	No
Bronchitis		
Emphysema		
Asthma		
Wheezing		
Pneumonia		
Tuberculosis (T.B.)		
Chronic or Frequent Cough		
Shortness of Breath		
Abnormal Chest X-Ray		
Any Lung Disease		
Chronis Nose/Sinus Complaints		

HEMATOLOGIC	Yes	No
Blood Clots in your Legs		
Pulmonary Embolism		
Phlebitis		
Easy Bleeding Tendency		
Easy Bruising Tendency		
Blood Clotting Abnormalities		
Blood or Plasma Transfusion		
Hemophilia		
Recurrent Nosebleeds		

GASTROINTESTINAL	Yes	No
Jaundice or Hepatitis		
Liver Disease		
Stomach Ulcers		
Frequent Heartburn		
Hiatal Hernia		

RENAL	Yes	No
Kidney Disease/Stones		
Frequent Bladder Infections		
Prostate Problems		

SKIN	Yes	No
Frequent Infections/Boils		
Cold Sores/Fever Blisters		

NEUROLOGICAL	Yes	No
Stroke		
Fainting Spells		
Seizures		

CARDIOVASCULAR	Yes	No
Mitral Valve Prolapse		
Anemia		
High Blood Pressure		
Chest Pain/Angina		
Heart Attack		
Irregular Heartbeats		
Congestive Heart Failure		
Rheumatic Fever		
Heart Murmurs		
Heart Blocks		
Low Potassium		
Abnormal EKG (heart recording)		
Pacemaker		
Any Heart Disease		
Sickle Cell Disease		

MUSCULOSKELETAL	Yes	No
Arthritis		
Bone, Joint, Muscle Trouble		

METABOLIC	Yes	No
Recent Unexpected Weight Loss		
Diabetes		
Thyroid/Goiter Problems		
Night Sweats/Fever		

VISION	Yes	No
Glaucoma		
Wear Contacts		

MENTAL	Yes	No
Do you, or have you had		
Significant emotional problems?		
Any Recent Emotional Crisis?		

Ladies	Yes	No
Any possibility You Are Pregnant?		

Paradise Valley Cosmetic Surgery Center/Paradise Valley Surgical Recovery Center

Physician Orders For Patients Prescribed Medications From Home

Dr. _____ Patient: _____

Date: _____

Please include name, dose, frequency and route of administration:

Medication(s):	Dosage	Route	Frequency	Why do you take this medication?	Last dose taken
Example: Inderal	**40mg**	**by mouth**	**twice a day**	**High blood pressure**	**6:00am 3/9/06**

- ❑ Above medications from home are in a separate labeled bag with patient belongings for Recovery center
- ❑ Homeopathic meds brought from home to be left at patient's bedside for self administration
- ❑ Patient did **not** bring above medications from home

If patient is going to the Surgical Recovery Center;

Physician Signature: _____ Date: _____

updated 8/06