



**FARAHMAND  
PLASTIC SURGERY**

**Patient Registration Form**

Date \_\_\_\_\_

Mr

Mrs.

Miss

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Marital Status (circle one)

Single

Married

Divorced

Widowed

Social Security # \_\_\_\_\_

Referred by/How did you hear of us?  
\_\_\_\_\_

Patient's Age \_\_\_\_\_

Date of Birth \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Parent/Guardian's name and place of employment if patient is a minor  
\_\_\_\_\_

In case of emergency, who should be notified?

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

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell \_\_\_\_\_

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Audrey Farahmand MD • Plastic and Reconstructive Surgeon  
13710 Metropolis Avenue Unit #104 Fort Myers, FL 33912  
Phone (239) 332-2388 • Fax (239) 332-2382 • [www.farahmandplasticsurgery.com](http://www.farahmandplasticsurgery.com)



**Health History**

**Date** \_\_\_\_\_

Confidential Record: Information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. Dr. Farahmand will use the information you provide in her decision regarding your care.

**Patient Name:** \_\_\_\_\_

	Last		First	Middle
<b>1. Have you ever had:</b>	<b>Yes</b>	<b>No</b>	<b>5. Family Physician</b>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<b>6. Are you allergic to:</b>	<b>Yes</b> <b>No</b>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/> <input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Novacaine	<input type="checkbox"/> <input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Other drugs (list) _____	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>		
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<b>7. List medications you take:</b> _____	
HIV	<input type="checkbox"/>	<input type="checkbox"/>	_____	
			_____	
<b>2. Do you Have:</b>	<b>Yes</b>	<b>No</b>	<b>8. Do you smoke?</b>	<b>Yes</b> <b>No</b>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
Dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how many packs per day: _____	
Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>	How many years _____	
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>		
Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<b>9. Do you consume alcoholic</b>	<b>Yes</b> <b>No</b>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	beverages daily	<input type="checkbox"/> <input type="checkbox"/>
<b>3. Do you take:</b>	<b>Yes</b>	<b>No</b>	<b>10. List operations you have had</b> _____	
Vitamin E	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Blood Thinner Meds	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Heart medications	<input type="checkbox"/>	<input type="checkbox"/>		
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<b>11. List any medical problem not</b>	
Diuretics (water pills)	<input type="checkbox"/>	<input type="checkbox"/>	previously mentioned: _____	
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	_____	
<b>4. Do you take or have you</b>			<b>12. Do you have</b>	<b>Yes</b> <b>No</b>
<b>ever taken</b>	<b>Yes</b>	<b>No</b>	A living will	<input type="checkbox"/> <input type="checkbox"/>
Steroids (cortisone, prednisone)	<input type="checkbox"/>	<input type="checkbox"/>	A health care surrogate and /or	
			Power of attorney	<input type="checkbox"/> <input type="checkbox"/>
			<b>13. Are you currently under psychiatric care</b>	<input type="checkbox"/> <input type="checkbox"/>
			<b>14. Do you have a psychiatric diagnosis?</b>	<input type="checkbox"/> <input type="checkbox"/>
			<b>15. Have you ever or are currently taking</b>	<input type="checkbox"/> <input type="checkbox"/>
			<b>Medication for a psychiatric diagnosis?</b>	<input type="checkbox"/> <input type="checkbox"/>