THE WOMEN'S HEALTH EXPERTS

PLASTICS PATIENT REGISTRATION INFORMATION FORM (PLEASE PRINT)

Today's Date			
Name		Nickname/Preferred Name	
DOB	Age	Marital Status	
Weight lbs.		Height ft. in.	
What Procedure(s) are you considering?			
Home Address	City	State	Zip
Cell#	Home#	Work#	
The best time to contact	☐ A.M. ☐ P.M.	On my: ☐ Cell phone	☐ Home phone
Email address			
Referral Source / How did you hear about Viva Eve?			
Referring Provider (if applicable)	Referring Provider Address	Referring Provider Phone Number	
Primary Care Provider	Primary Care Provider Address	Primary Care Provider Phone Number	
Emergency Contact Name	Emergency Contact Phone	Relationship	

PRIMARY INSURANCE INFORMATION

Insurance Name		
Subscriber ID#	Group#	
Subscriber Name	Date of Birth	SSN

SECONDARY INSURANCE INFORMATION

Patient Relationship to Subscriber (Please check) ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other

Subscriber ID#	Group#	
Subscriber Name	Date of Birth	SSN

PHARMACY INFORMATION

Pharmacy Name	Pharmacy Phone	Pharmacy Address

viva eve

THE WOMEN'S HEALTH EXPERTS

HEALTH INFORMATION (PAGE 1 OF 5)

1. Are you a smoker? ☐ Yes ☐ No
   If so, please tell us how much and for how long. If you recently quit, please tell us how long ago: ___________________________

2. Are you a regular coffee, tea or caffeinated soda drinker? ☐ Yes ☐ No

3. Do you consume alcohol on a regular or social basis? ☐ Yes ☐ No

4. Do you exercise regularly? ☐ Yes ☐ No

PHYSICIANS REGULARLY SEEN: If you are presently under the care of any type of doctor -- whether an internist, primary care or specialist -- for a current, chronic or long term medical condition -- please list the doctor(s) names, phone numbers and specialty. If you do not have an internist or primary care physician, please indicate that.

Please note: We will not contact any of your physicians without your express permission.

ALLERGIES AND SENSITIVITIES:			EXPLANATION:
Penicillin or other antibiotics	Yes	No	
Morphine, codeine, demerol or other narcotics	Yes	No	
Sedative or anxiety medication -- Valium, Xanax, Ativan etc.	Yes	No	
Any of the classes of depression medication including Zoloft, Prozac or MAO Inhibitors	Yes	No	
Anti-nausea or anti-seizure medication or neuroleptics	Yes	No	
Novocaine or other local anesthetics	Yes	No	
Sodium Pentothal or other anesthetics	Yes	No	
Sulfa drugs	Yes	No	
Tetanus antitoxin or other serums	Yes	No	
Adhesive tape	Yes	No	
Iodine or Methiolate, Phisohex or other antiseptics	Yes	No	
Any other drug or medication	Yes	No	
Any foods such as eggs, milk or chocolate	Yes	No	
Do you have a latex allergy	Yes	No	
Do you have a surgical tape allergy	Yes	No	
Any reactions to puffers or inhalers	Yes	No	

viva eve

THE WOMEN'S HEALTH EXPERTS

HEALTH INFORMATION (PAGE 2 OF 5)

DRUGS RECENTLY TAKEN: Please inform us of any of the following drugs you have taken within the past six months (unless another time frame is specified)

Cortisone/steroids (taken within the past 2 years)	Yes	No	
Antidepressants (including MAO inhibitors)	Yes	No	
Anticoagulants (blood thinners)	Yes	No	
Tranquilizers	Yes	No	
Hypertensives (high blood pressure medication)	Yes	No	
Cardiac drugs (Pronestyl, digitalis, etc.)	Yes	No	
Inderal	Yes	No	
Accutane (within the past year)	Yes	No	
Diuretics (water pills)	Yes	No	
Anti-diabetic drugs	Yes	No	
Any other prescribed or non-prescribed medications	Yes	No	NONE
Please list			
Any homeopathic, herbal or vitamin preparations	Yes	No	NONE
Please list			

In the following space, please provide a complete list of all drugs/preparations/medications which you CURRENTLY take, including those listed above. This list is helpful in avoiding possible cross-drug reactions.:

DETAILED MEDICAL HISTORY

DO YOU OR A MEMBER OF YOUR FAMILY HAVE A HISTORY OF:

			WHO/WHAT
Diabetes (High Blood Sugar)	Yes	No	
High Blood Pressure	Yes	No	
Low Blood Sugar	Yes	No	
Mitral valve prolapse	Yes	No	
Pacemaker	Yes	No	
Rheumatic heart disease	Yes	No	
Coronary Surgery	Yes	No	
Angina	Yes	No	
Atrial Fibrillation	Yes	No	
Heart Disease - other	Yes	No	
Lung Disease	Yes	No	
Kidney Disease	Yes	No	
Pulmonary embolus	Yes	No	
Neurological disorders	Yes	No	
Thyroid, pancreatic or other endocrine disorders such as hypoglyce-mia (low blood sugar)	Yes	No	
Phlebitis	Yes	No	
Migraine headaches	Yes	No	
Abnormal bleeding	Yes	No	
Abnormal clotting	Yes	No	
Anesthetic problems	Yes	No	

viva eve

THE WOMEN'S HEALTH EXPERTS

HEALTH INFORMATION (PAGE 3 OF 5)

DETAILED MEDICAL HISTORY (Continued)

DO YOU OR A MEMBER OF YOUR FAMILY HAVE A HISTORY OF:			WHO/WHAT
Cancer (including skin)	Yes	No	
Tuberculosis	Yes	No	
Anemia	Yes	No	
Hepatitis	Yes	No	
Prostate disorders	Yes	No	
Acid regurgitation (heartburn)	Yes	No	
Rheumatic fever	Yes	No	
Emphysema	Yes	No	
Any weight change past 12 months	Yes	No	
Stomach problems	Yes	No	
Ulcers	Yes	No	
Urination problems	Yes	No	
Do you wear contact lenses	Yes	No	
Do you wear glasses	Yes	No	
Do you wear dentures	Yes	No	
Do you use a hearing aid	Yes	No	
Do you form keloids	Yes	No	
Do you form thick red raised scars on your body	Yes	No	
Have you ever undergone scar revisions or treatment for improving scarring	Yes	No	
Other serious illness or medical problems	Yes	No	
FEMALE PATIENTS			
Number of pregnancies Number of children			
Do/did you breast feed	Yes	No	
Last menstrual period	Yes	No	
Have you suffered any miscarriages?	Yes	No	
When was your last dental, oral surgery or dental cleaning?			

BLEEDING PROFILE			EXPLANATION
Do you have any problems with bleeding in general?	Yes	No	
After a razor cut?	Yes	No	
After a tooth extraction?	Yes	No	
After a previous surgery?	Yes	No	
After a delivery?	Yes	No	
Do you bruise easily or remain brused for long periods of time?	Yes	No	
HAve you ever received blood transfusions or blood products (plasma, platelets, etc.)? PLEASE GIVE DETAILS	Yes	No	
Is there a family history of bleeding problems?	Yes	No	
Do you use aspirin regularly?	Yes	No	
NSAIDS such as Advil, Motrin, Ibuprofen, Aleve, Naproxen etc.?	Yes	No	
Do you take vitamin E?	Yes	No	
Do you take blood thinners?	Yes	No	

viva eve

THE WOMEN'S HEALTH EXPERTS

HEALTH INFORMATION

FREQUENCY

Do you take any of the following drugs which contain	aspirin	Yes	No
	Darvon	Yes	No
	Percodan	Yes	No
	Fiorinal	Yes	No
	Ascriptin	Yes	No
	Empirin	Yes	No
	Alka Seltzer	Yes	No
	Alka Seltzer Plus	Yes	No
	Coricidin	Yes	No
	Excedrin	Yes	No
	Midol	Yes	No
	Bufferin & others	Yes	No

Please see separate accompanying list of drugs and foods known to cause bleeding and list any taken regularly.
Also, please list any other foods or drugs you feel may make you bruise easily:

Please list any other medical problem(s) not included above:

PREVIOUS PERSONAL AND FAMILY SURGICAL HISTORY

1. Have you had previous surgery? Please list:

2. If so, please indicate type(s) of anesthesia as well as any complications/reactions

☐ Local Anesthia
☐ General Anesthesia
☐ Spina/Epidural
☐ Sedation
☐ Twilight Sleep

3. Have there been unexpected deaths or complications from anesthesia (including the dentist office) in any members of your family?

☐ Yes ☐ No Please explain:

4. Is there a personal or family history of unexplained high fevers (known as malignant hyperthermia) following drug administration or general anesthesia?

☐ Yes ☐ No Please explain:

T: (718) 897-5331 • info@vivaeve.com
FHMS, PC, Madison Medical Services, PLLC, Meridian Medical Services, PLLC 1986 Medical, PLLC, 9909 Medical, PLLC , J. Gohar Medical P.C.

HEALTH INFORMATION (PAGE 5 OF 5)

SURGICAL HISTORY (Continued)

5. Is there a personal or family history of unexplained high fevers following surgery?

☐ Yes ☐ No Please explain:

6. Is there a personal history of dark or cola-colored urine following surgery?

☐ Yes ☐ No Please explain:

7. Is there a personal or family history of masseter muscle rigidity (MMR)? This is a severe, sustained contracture of the jawbone muscle.

☐ Yes ☐ No Please explain:

8. Do you have a personal or family history of the following

☐ Scoliosis or Kyphosis (hunchbacked)
☐ Muscle disorder
☐ Spontaneous muscle cramp
☐ Squint
☐ Any other problems with muscle function

9. Is there anything else you think the doctor should know?

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature	Date