PATIENT REGISTRATION **Use black ink**

Ricardo Izquierdo, M.D.

FACE AND BODY
Plastic Surgery

Date_____
Name_____
Address_____
City_____ State_____ Zip_____
Date of Birth_____ Age_____ Gender_____
Email_____
Marital Status_____
Home Phone_____ Cell Phone_____
Who referred you?_____ Other Source ☐ internet ☐ ad ☐ patient
Check all that apply

Employer/School Name_____
Employer/School Address_____
City_____ State_____ Zip_____

PHYSICIAN INFORMATION
Family Physician_____Address_____
City_____State_____Zip_____Phone_____

REASON FOR TODAY'S APPOINTMENT _____

Do you have questions/concerns about your skin? Yes___ Not at this time___

Please check any concerns:

Additional Skin Care Questions_____

☐ wrinkles	☐ aging	☐ rosacea
☐ sun damage	☐ dry skin	☐ acne scarring
☐ uneven skin tone/ discoloration	☐ oily skin	☐ skin care products

MEDICAL HISTORY

Height _____ Weight_____

Past Medical History

☐Abnormal heart beat	☐ Scarring problems	☐ Heart attack
☐Anesthesia problems	☐ Seizures	☐ Heart history
☐Asthma	☐ Stomach problems	☐ Intestinal problems
☐Breast history	☐ Bleeding history	☐ Liver history
☐Chest pain (angina)	☐ Blood clots	☐ Stroke
☐Hypertension	☐ Breathing problems	☐ TB
☐Jaundice	☐ Cold sores	☐ Thyroid history
☐Kidney history	☐ Diabetes	

Past Surgical History_____

Allergies_____

LATEX Allergy yes ○ no ○

Malignant hyperthermia yes○ no ○

Current Medications_____

☐ Aspirin ☐ Advil® ☐ Nuprin® ☐ Coumadin® ☐ Aleve® ☐ Celebrex®

☐ Accutane®

☐ Diet pills

☐ Herbal/

Vitamins_____

Alcohol Use yes ○ no ○ Frequency/Amount_____

Smoker yes ○ no ○

Date of last menstrual period_____ Date of last PAP smear_____

Date of last tetanus_____ Date of last mammogram_____

MEDICAL PHOTOGRAPHS

Photographs may be taken during the course of my treatment in order to demonstrate my condition or disorder, and subsequent therapy.

_____ _____

Signature of patient (or authorized person) date