MEYERS AESTHETIC CENTER

1400 Dry Creek Drive Longmont, CO 80503
(303) 682-3386 / Fax: (303) 682-3398
www.EyeCareSite.com

REGISTRATION FORM

Date: 06/16/2008

Patient Name : _____ Account # : _____

Address : _____

Date of Birth : _____ ALLERGIES: _____

Sex : _____ Social Security # : _____

Home Phone Number : (____)_____ Work Phone # : (____)_____

Emergency Contact : _____

Emergency Phone : (____)_____

Whom may we thank for referring you to our office?

_____

FINANCIALLY RESPONSIBLE PARTY

Name : _____ SSN : _____

Address: _____

Home Phone: (____)_____ Work Phone: (____)_____

CHECK-OUT NOTE:

PLEASE STOP at the CHECK-OUT COUNTER before leaving our office.

Payment for office services is due on the day of service.

Date: _____ Signature: _____

Patient Information / Evaluation

Name _____ Date _____

In your own words, what would you like to change and/or improve?

_____

_____

_____

_____

_____

_____

_____

Have you previously had cosmetic surgery? ____ Yes ____ No

What procedures have you had done?

___ Face lift
___ Dermabrasion (sanding)
___ Botox
___ Liposuction
___ Laser surgery
___ Eyelid surgery
___ Breast augmentation
___ Tummy tuck
___ Collagen injections
___ Forehead lift
___ Chemical peel
___ Fat injections
___ Facial implants
___ Other _____

Did you have any problems with: ____ healing ____ scarring ____ pigmentation ____ infection
____ bleeding ____ persistent redness ____ Other complications (please describe) _____

_____

_____

After minor pimples, cuts, scratches or blemishes, does your skin stay: ____ red ____ brown
How long does it usually stay discolored? ____ days ____ weeks ____ months

Are you using either of the following on your skin? ____ Retin A ____ Alphahydroxy or glycolic acid
(which brand and what strength) _____

Do you have a problem with acne or breaking out? ____ Yes ____ No
If yes, please list any medications you have been on for its management: _____

_____

Are you currently on them? ____ Yes ____ No
Have you ever been on Accutane? ____ Yes ____ No
Do you get frequent large pimples or cysts? ____ yes ____ No

Are you allergic to any topical ____ makeup ____ cream ____ lotion ____ antibiotic
____ Other preparation _____

Do you get cold sores (fever blisters) or other skin infections? ____ Yes ____ No
____ Other (please list) _____

Is there anything about your skin and the way it heals or reacts that is unusual or special? ____ Yes ____ No
If yes, please describe _____

_____

Do you have any history of mental health problems? ____ Yes ____ No
If yes, please explain _____

_____

_____ _____
Signature Date

HEALTH HISTORY FORM

		DATE:
Name:		Family Physician:
Age:	Occupation:	Last Eye Exam:

Do you have any of following medical problems?	Self History	Family History	If yes please explain:
Ears, Nose, Throat (sinus, sore throat)	Y/N	Y/N	
Heart (Chest pain, irregular beat)	Y/N	Y/N	
Breathing Problems (short breath)	Y/N	Y/N	
GI (diarrhea, vomiting, stomach pain)	Y/N	Y/N	
Kidney Disease (pain, blood in urine)	Y/N	Y/N	
Neurological (seizure, stroke, weak)	Y/N	Y/N	
Skin Problems	Y/N	Y/N	
Arthritis (joint aches or pains)	Y/N	Y/N	
Psychiatric Problems	Y/N	Y/N	
Diabetes	Y/N	Y/N	
Migraine Headaches	Y/N	Y/N	
Asthma	Y/N	Y/N	
Bleeding Problems	Y/N	Y/N	
Anemia	Y/N	Y/N	
Cancer	Y/N	Y/N	
Thyroid Problems	Y/N	Y/N	
High Blood Pressure	Y/N	Y/N	
HIV/Aids/Hepatitis	Y/N	Y/N	
Other Medical Problems:			

Eye History	Self	Family	If yes please explain
Glaucoma	Y/N	Y/N	
Diabetes	Y/N	Y/N	
Retinal Problems	Y/N	Y/N	
Lazy Eye	Y/N	Y/N	
Corneal Problems	Y/N	Y/N	
Eye Injury	Y/N	Y/N	
Macular Degeneration	Y/N	Y/N	
Cataracts	Y/N	Y/N	
Eye Muscle Surgery	Y/N	Y/N	
Other	Y/N	Y/N	
All past surgeries:			

Medications
Non Prescription Drugs
Allergies to medicines or food: