JANJUA FACIAL SURGERY REGISTRATION INFORMATION

Today's Date: _____

Patient: _____ _____ _____
Last MI First

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ ***Preferred # to Contact: Home / Work / Cell (Circle One)***

Can we leave a message on the preferred #? Yes / No

Email: _____ ***Can we send you office newsletters or other correspondence? Yes / No***

Sex: F / M SS #: _____ Date of Birth: _____ Age: _____

Marital Status: Single / Married / Divorced / Widowed / Separated *(Circle One)*

In case of emergency, notify: _____ Phone: _____

Name of Your Medical Insurances: _____

Primary Insured's Name:_____ DOB: _____ SS# _____

Who can we discuss **your or your child's** health care with? Spouse / Parent / Doctor / Friend _____

How did you find us: Insurance Directory / Newspaper / Yellow pages / Doctor / Friend _____

Other _____

Your Drug Store: _____

City: _____ State: _____

Prescriptions are sent electronically to your pharmacy. Please make sure that this is the appropriate pharmacy you would like us to use. If it changes at any time, please let us know.

I have read the "Office & Financial Policies" & "Notice of Privacy Practices", which details Janjua Facial Surgery's HIPAA Compliance.

_____ _____
Signature **Date**

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HEALTH HISTORY

Reason for today's visit: _____

Drug Allergies: Yes / No Names of the drugs: _____

Other Allergies (such as food, dust, pollen etc.): _____

Height: _____ Ft _____ (In) Weight: _____ (Lbs) Stress level (1 – 10): _____

Family Physician (Internist or Primary Care Physician): _____

Do you have any of these medical problems? Please include all past medical conditions or conditions currently under control. Withholding medical information can adversely affect your health and treatment plan.

• Depression	YES / NO	Bipolar	YES / NO
• Anxiety	YES / NO	Schizophrenia	YES / NO
• Seizure Disorder	YES / NO	Hepatitis	YES / NO
• Stroke	YES / NO	Hiatus Hernia	YES / NO
• Cataracts	YES / NO	Muscle / Bone Disease	YES / NO
• Glaucoma	YES / NO	HIV	YES / NO
• Hearing Loss	YES / NO	Acid Reflux	YES / NO
• Asthma	YES / NO	Anemia	YES / NO
• High Blood Pressure	YES / NO	Bleeding Disorder	YES / NO
• Heart Attack	YES / NO	Angina	YES / NO
• Head and Neck Problems	YES / NO	Thyroid Disorder	YES / NO
• Breast Disease	YES / NO	Diabetes	YES / NO
• Weight Loss	YES / NO	Cancer (including skin)	YES / NO
• Sweats / Chills	YES / NO	Loss of Appetite	YES / NO
• Vertigo (Dizziness)	YES / NO	Fever	YES / NO
• Emphysema	YES / NO	Tinnitus (ringing in ears)	YES / NO

- Change In Vision / Smell / Taste / Swallowing / Hearing / No Change (Please circle what applies)

Other Medical Conditions or hospitalizations not listed above: _____

Previous Surgeries: _____

Medications (including herbs, vitamins, over the counter drugs): _____

_____

Occupation: _____ Marital Status: Married / Divorced / Single / Widowed *(Circle One)*

Tobacco Use:	YES / NO	If yes, how much? _____
Alcohol Use:	YES / NO	If yes, how much? _____
Illegal Drug Use:	YES / NO	
Children:	YES / NO	If yes, how many? _____
Pets:	YES / NO	DOGS / CATS / OTHER: _____

Family History of Medical Illnesses (Indicate the relationship to the person and the medical condition):

_____

Comments (Anything else that might help us understand your illness): _____

_____

Patient Signature

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