



sharon giese, md

BOARD CERTIFIED PLASTIC SURGEON



Patient Registration Form

Today's Date: ___/___/_____

Name: _____ Age: _____ DOB: ___/___/_____

Name by which you prefer to be addressed by office staff _____

Home Address: _____
(Street) (Apt.)

(City) (State) (Zip Code)

Home phone: () Business phone: () Cell phone: ()

Email: _____

If visiting NY, Local Address _____ Phone: ()

Occupation: _____ Employer: _____

Business Address: _____

Contact in case of emergency _____
(Name) (Phone)

Pharmacy: _____ Address: _____ Phone: ()

How did you hear about Dr. Giese? _____

Other than the services we have already provided for you, what additional services would you like to learn about?
Please check all that apply.

- | | | |
|--|---|--|
| <input type="checkbox"/> Cellulite | <input type="checkbox"/> Drooping Eyelids | <input type="checkbox"/> Juvederm/Restylane/Radiesse |
| <input type="checkbox"/> Breast Size/shape | <input type="checkbox"/> Dark Under Eye Circles | <input type="checkbox"/> Fine Lines/Wrinkles |
| <input type="checkbox"/> Abdominal Area | <input type="checkbox"/> Neck Wrinkles | <input type="checkbox"/> Chemical Peel |
| <input type="checkbox"/> Body Contouring | <input type="checkbox"/> Brown Spots/Age spots/Freckles | <input type="checkbox"/> Crepey Hands/Knees/Elbows/Stomach |
| <input type="checkbox"/> Hips/Legs | <input type="checkbox"/> Skin Care Products | <input type="checkbox"/> Length/Fullness Of Eyelashes |
| <input type="checkbox"/> Facial Contouring | <input type="checkbox"/> Facial Fullness/Drooping | <input type="checkbox"/> Urine Leakage |
| <input type="checkbox"/> Facial Fullness/Redness | <input type="checkbox"/> Injectable Treatments | <input type="checkbox"/> Pain During Intercourse |
| <input type="checkbox"/> Jowls | <input type="checkbox"/> Thin Lips | <input type="checkbox"/> Vaginal Dryness |
| <input type="checkbox"/> Drooping Brow | | <input type="checkbox"/> Vaginal Rejuvenation |



Medical History

Height: ___ feet ___ inches Weight: ___ pounds

Marital Status: _____ Number of Children: ___ Ages of Children: _____

The reason for my visit is: _____

Prior Plastic Surgery History: Please check here if none: _____ Otherwise, please list below: _____

1) _____ date: _____ 2) _____ date: _____

3) _____ date: _____ 4) _____ date: _____

Other: _____

Current Medication(s): Please check here if none: _____ Otherwise, please list below: _____

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

Herbal Medications: _____

Previous Medical Operation(s): Please check here if none: _____ Otherwise, please list below: _____

1) _____ date: _____ 2) _____ date: _____

3) _____ date: _____ 4) _____ date: _____

Any history of trouble with anesthesia _____

Medical Problems (Please Check Where Appropriate): Please check here if none:

Diabetes High Blood Pressure Heart Kidney Digestive Muscle/Bone Skin Nervous System

Describe/Others: _____

Drug Allergies: None 1) _____ 2) _____ 3) _____

Do you bleed easily? Yes No

Do you smoke? Yes No

If yes, how much? _____ For how many years? _____ How long since your last cigarette? _____

Alcohol Consumption: Never Rarely Occasionally Often

History of Eating Disorders: _____

Do you see a psychiatrist? Yes No If yes, how many times per week: _____

Are you taking any antidepressants? Yes No

Any history of drug use, including marijuana _____

Current Physicians Address/Location: _____

1) _____

2) _____

3) _____

Above information truthful and complete: _____

Signature

