BEVERLY FISCHER, MD
THE ADVANCED CENTER FOR PLASTIC SURGERY
(410) 308-4700

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Home Phone: _____ Other Phone: _____

Cell Phone: _____ Restrictions for contacting you (circle): Yes ❑ No ❑

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Gender (circle): Male ❑ Female ❑ Transgender ❑ Gender Fluid ❑

Marital Status (circle): Single ❑ Married ❑ Other ❑ Spouse/Partner's Name: _____

Patient's Employer/School: _____ Occupation: _____

Work Phone: _____ Is it okay to call you at work (circle)? Yes ❑ No ❑

Work Address: _____ City: _____ State: _____ Zip: _____

How did you hear about us? _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Emergency Contact Address: _____

Home Phone: _____ Other Phone: _____

Cell Phone: _____

_____ _____

Signature/Guardian Date

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SCHEDULING

When you ask us to schedule a surgery for you, we must take several steps to prepare for the day of your surgery:

1. Reserve the operating room.
2. Order and pay for any surgical supplies needed for your surgery.
3. Secure the necessary staff that will be needed, and/or provide coverage to free them up from their other responsibilities.
4. Arrange anesthesia coverage for your case. We must guarantee that we will pay them for this time, whether or not you go through with your procedure.
5. We must turn down every other patient who wants surgery on the day and time we have reserved for you.

Because of these financial obligations and time commitments we must make, we ask that you be certain about your desire for surgery and be positive that you have the funds available before asking us to schedule your surgery.

Health Information (please circle)			
Heart Trouble / Heart Attack / Heart Failure	Yes ❑ No ❑	Glaucoma or Eye Problems	Yes ❑ No ❑
Palpitation or Irregular Pulse	Yes ❑ No ❑	Visual Disturbances	Yes ❑ No ❑
Heart Murmur	Yes ❑ No ❑	Error in Refraction	Yes ❑ No ❑
Stroke	Yes ❑ No ❑	Hepatitis	Yes ❑ No ❑
Hypertension	Yes ❑ No ❑	Jaundice	Yes ❑ No ❑
Blood Pressure Abnormality	Yes ❑ No ❑	Gallstones or Gallbladder Trouble	Yes ❑ No ❑
Abnormal EKG	Yes ❑ No ❑	Cirrhosis of the Liver	Yes ❑ No ❑
Rheumatic Fever	Yes ❑ No ❑	Alcoholism	Yes ❑ No ❑
Digitalis Treatment	Yes ❑ No ❑	Drug Dependency	Yes ❑ No ❑
Shortness of Breath	Yes ❑ No ❑	Esophageal Varices	Yes ❑ No ❑
Chest Pain	Yes ❑ No ❑	Frequent Indigestion	Yes ❑ No ❑
Asthma	Yes ❑ No ❑	Ulcers	Yes ❑ No ❑
Bronchitis	Yes ❑ No ❑	Gastritis	Yes ❑ No ❑
Pneumonia	Yes ❑ No ❑	Colitis	Yes ❑ No ❑
Tuberculosis	Yes ❑ No ❑	Constipation	Yes ❑ No ❑
Smoker's Cough	Yes ❑ No ❑	Tarry or Bloody Bowel Movements	Yes ❑ No ❑
Emphysema	Yes ❑ No ❑	Hemorrhoids	Yes ❑ No ❑
Coughing / Spitting / Vomiting of Blood	Yes ❑ No ❑	Goiter or Thyroid Disorders	Yes ❑ No ❑
Hay Fever	Yes ❑ No ❑	Diabetes	Yes ❑ No ❑
Major Allergies	Yes ❑ No ❑	Skin Disorders	Yes ❑ No ❑
Palsy or Paralysis	Yes ❑ No ❑	Arthritis	Yes ❑ No ❑
Nervous Breakdown	Yes ❑ No ❑	Fracture of Neck or Spine	Yes ❑ No ❑
Nervous Disorder	Yes ❑ No ❑	Bleeding Tendency or Disorder	Yes ❑ No ❑
Insomnia	Yes ❑ No ❑	Missed or Irregular Last Menstrual Period	Yes ❑ No ❑
Drug Habit	Yes ❑ No ❑	Nasal Airway Obstruction	Yes ❑ No ❑
Self-Destructive Tendencies	Yes ❑ No ❑	Breast Cysts / Breast Tumors / Abscesses	Yes ❑ No ❑
Psychiatric Hospitalization or Care	Yes ❑ No ❑	Nipple Discharge (Apart from Normal Lactation)	Yes ❑ No ❑
Thyroid Problems	Yes ❑ No ❑	Kidney Disorder	Yes ❑ No ❑
Kidney or Renal Disease	Yes ❑ No ❑	Blood Transfusion	Yes ❑ No ❑
Piercings (other than ears)	Yes ❑ No ❑	Seizures / Convulsions / Fainting Spells	Yes ❑ No ❑
Positive Blood Test for HIV / AIDS / Hepatitis	Yes ❑ No ❑	Black Outs	Yes ❑ No ❑
Family History of Cancer / Heart Trouble / Hepatitis	Yes ❑ No ❑	Dentures, Bridges, Capped Teeth or Crowns	Yes ❑ No ❑
Family History of Anesthesia Problems	Yes ❑ No ❑	Loose Teeth	Yes ❑ No ❑
Family History of Bleeding problems	Yes ❑ No ❑	Cosmetic Bonding to Teeth	Yes ❑ No ❑

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AREAS OF INTEREST (check all that apply)

FACIAL PROCEDURES	BREAST PROCEDURES	BODY PROCEDURES	IN OFFICE (non-invasive)
❑ Laser Resurfacing	❑ Breast Augmentation	❑ Abdominoplasty	❑ Botox/Dysport
❑ Blepharoplasty: Eyelid Surgery	❑ FTM Top Surgery	❑ Panniculectomy	❑ Filler Injections: Juvederm,Restylane, Voluma, and/or Sculptra
❑ Cheek Implants	❑ Gynecomastia	❑ Brachioplasty: Arm Lift	❑ Skin Care
❑ Chin Augmentation	❑ Breast Implant Exchange	❑ Labiaplasty	❑ Facial Peel
❑ Facelift / Uplyft / LazerLift	❑ Breast Reduction	❑ Full Body Lift	❑ Microneedling
❑ Fat Transfers	❑ Mastopexy: Breast Lift	❑ Thigh Lift	
❑ Otoplasty: Ear Surgery	❑ Nipple Reconstruction	❑ Ultrasonic Liposuction/ Body Contouring	❑ Vaginal Rejuvenation
❑ Brow Lift		❑ Smart Lipo	❑ Sweet Spot Shot
		❑ Cellulaze	❑ BioTE: Bio-Idenical Hormone Balance for Men and Women
		❑ Scar Revision	

Medical/Surgical History

Type of Surgery Date Purpose (if necessary)

Medications: (current and that have been used in the last 6 months; including birth control)

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Name/Dosage
Frequency

Purpose

_____

_____

_____

List all drug allergies:

_____

_____

_____

Please answer the following questions (circle and/or explain):

1. Drugs such as Suboxone or Methadone can have a lethal effect combined with anesthetic drugs. Do you have a history of or are you currently taking synthetic opioids? Yes ❑ No ❑

2. Are you currently being treated for chronic pain? Yes ❑ No ❑

   Other: _____

3. Do you smoke? _____ Currently ❑ / Previous ❑ / Never ❑

   How much are/were you using tobacco? _____ For how long? _____

   When did you quit? _____

4. Have you ever been diagnosed with a Latex allergy? Yes ❑ No ❑Do you react abnormally to medication? Yes ❑ No ❑
   If so, please list medication(s): _____

5. Have you or a member of your family ever had any difficulties with any medications, drugs, or gases used for anesthesia (i.e. muscle weakness, jaundice, breathing problems, unexpected fever)? Yes ❑ No ❑

   If so, when and where? _____

6. Have you ever been on cortisone or steroid treatment? Yes ❑ No ❑

   If so, when? _____

7. Have you ever been under psychiatric care? Yes ❑ No ❑
   When? _____ Why? _____

8. Have you had any recent blood work done? Yes ❑ No ❑
   Where? _____

9. Do you have cocktails regularly, or consume regular amount of alcoholic beverages (including beer, wine, or other alcohol)? Yes ❑ No ❑ If so, how much? _____

10. Are you pregnant? Yes ❑ No ❑

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11. When was your last menstrual period? _____

    a. How many pregnancies? _____

    b. Breast fed? Yes ❑ No ❑ If so, how long? _____

12. When was your last ...

    a. Physical examination: _____

       By whom? _____

    b. Eye exam: _____

       By whom? _____

    c. Chest X-ray: _____

    d. EKG: _____

13. Who is your current Primary Care Physician? _____

Please list all physicians presently caring for you:

_____

_____

_____

_____

_____

_____

Is there anything else that you think the doctor should know?

_____

_____

_____

_____

_____

_____