

Swansea Laser Clinic Patient Registration Form

Mr Max Murison

Consultant Plastic Surgeon

INFORMATION FOR CLINICAL HISTORY

IMPORTANT: Please complete all relevant sections and bring this form with you to your first appointment

Today's Date: _____

Patient's Name: _____
Title First Middle Last

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

Home Address: _____
Street City County Post Code

Home Phone: _____ Mobile Phone: _____

Occupation: _____ Employer: _____ Work Phone: _____

Work Address: _____
Street City County Post Code

email: _____

Emergency contact: _____ Relationship: _____ Phone: _____

How may we contact you? *Please tick all that apply*

Mobile email Land line Work telephone

General Practitioner

Dr's First Name _____ Last Name _____ Practice Name _____

INSURANCE INFORMATION *if Applicable*

Insurance Company: _____ ID Number: _____

Group Number: _____ Insured's Name: _____

Authorisation code: _____

How were you referred to our clinic?

Friend: Name _____ Doctor: Name _____

Staff: _____

MEDICAL HISTORY

Height: _____ Weight: _____

Do you smoke? Yes No If so, how much? _____

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Please list any serious illnesses even if in the past: _____

Have you ever had any of the following (please answer every question)?

Allergy to adhesive tape Yes No Asthma Yes No Bruise/bleed easily Yes No
Diabetes Yes No Heart disease Yes No High blood pressure Yes No
Keloid scarring Yes No Kidney disease Yes No Lung disease Yes No

Other _____

List any medications taken on a daily basis such as blood thinner, aspirin, Birth Control, diuretics, blood pressure or heart medications, steroids, tranquillisers, hormones, Tretinoin, herbal drugs, Diet medications, Vitamins, etc. _____

Allergies to Medications: Yes No Please State which _____

Latex Allergy: Yes No

Have you taken steroids, i.e. Prednisolone, cortisone etc. or Roaccutane in the past 12 months:

Do you suffer from cold sores?: Yes No _____

HIV: Yes No

Please list all previous surgery with dates:

Surgery complications: _____

How did you hear out about us? _____

Procedures/Services of Interest:

Questions to discuss: _____

Important: Does your problem have any Medical, Physical or Psychological basis? Yes No

Patient's Signature

Date

Relationship, if not patient

Responsible Clinician

Mr M S C Murison

Date