OPHTHALMIC CONSULTANTS OF VERMONT

Gregory McCormick, MD • Cataract, Cornea & Refractive Surgery
Katherine Lane, MD • Cosmetic, Oculofacial Plastic & Reconstructive Surgery
David Shiple, MD • Cataract, Cornea & Comprehensive Ophthalmology

VERMONT LASER VISION AT TIMBER LANE

Cosmetic Patient Registration Form

Name: _____ Date: _____
Address: _____
City/State: _____ Country: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Date of Birth: _____ SS#: _____ ☐ Male ☐ Female
Occupation: _____

We would like to contact you from time to time for follow ups or with appointment reminders.

May we contact you via text message? ☐ Yes ☐ No
Cell Phone Number: (____) ____ - _____

May we contact you via email? ☐ Yes ☐ No
Email Address: _____

How did you hear about us?
Event: _____
RealSelf: _____
Friend/Relative Name: _____
Referring Physician Name: _____
Referring Eye Doctor-Name: _____
Cosmetic or eye plastic surgery website: _____
Other: _____

Current Ophthalmologist/Optometrist: _____
Primary Care Physician: _____ Address: _____
Medical Insurance: _____ Policy #: _____

In Case of Emergency Notify:
Name: _____ Relation: _____
Phone: _____
Permission to discuss your health care with your emergency contact? ☐ YES ☐ NO

Would you like to be contacted about new products, services, or special offers? ☐ Yes ☐ No
Preferred method: ☐ Email ☐ Phone ☐ Mail

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Cosmetic Pre-Treatment Questionnaire

Name: _____ **Date:** _____

Medical History:

Autoimmune disorders (Rheumatoid Arthritis, Collagen Vascular Disease, Sjogren's syndrome, Lupus)? ☐ Yes ☐ No

Eczema/Psoriasis	☐ Yes ☐ No	Skin Problems	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Easy bruising	☐ Yes ☐ No
Myasthenia Gravis	☐ Yes ☐ No	Bells Palsy	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No	Herpes Simplex virus (cold sores)	☐ Yes ☐ No
Pregnant/Nursing	☐ Yes ☐ No	Have you ever taken Accutane?	☐ Yes ☐ No
Slow healing or keloid formation?	☐ Yes ☐ No	Do you smoke?	☐ Yes ☐ No

Pigmentation disorders (vitiligo, post-inflammatory hyperpigmentation) ☐ Yes ☐ No

When you are exposed to sun, do you:

☐ Always burn ☐ Usually burn ☐ Sometimes burn ☐ Rarely burn ☐ Very rarely burn

Ocular History:

Do you have dry eyes? ☐ Yes ☐ No

Do you ever have swelling around your eyes upon awakening in the morning? ☐ Yes ☐ No

-After salty meals? ☐ Yes ☐ No

-Associated with seasonal or environmental allergies? ☐ Yes ☐ No

Have you ever had surgery around your eyes? ☐ Yes ☐ No If yes, please explain: _____

Cosmetic History:

Have you ever been treated with Botox or Dysport? ☐ Yes ☐ No If yes, when was your last treatment? _____

Which areas? ☐ Forehead lines ☐ Eyebrows ☐ Frown lines ☐ Crows feet ☐ Bunny lines ☐ Lips ☐ Chin

Adverse reactions? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been treated with fillers? ☐ Yes ☐ No If yes, when was your last treatment? _____

Which areas? ☐ Lower lids ☐ Eyebrows ☐ Forehead lines ☐ Smile lines ☐ Lips ☐ Perioral lines ☐ Chin

Do you have a history of cold sores, or herpes? ☐ Yes ☐ No

Adverse reactions? ☐ Yes ☐ No If yes, please explain: _____

In the last 6 weeks, have you undergone: ☐ Laser skin resurfacing ☐ Chemical peeling ☐ Dermabrasion ☐ Retin-A treatment

Please list your current medications and supplements: _____

_____

Are you currently on antibiotics? ☐ Yes ☐ No

Blood thinners: ☐ Aspirin ☐ Coumadin ☐ Plavix ☐ Pradaxa ☐ NSAIDS(Motrin, Ibuprofen, Advil, Pamprin etc) ☐ Ginko ☐ Garlic ☐ Green tea

Please list all known allergies: _____

********** For Office Use Only **********

Reviewed by: _____ Date: _____

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