VERMONT COSMETIC EYE SURGERY

COSMETIC PATIENT REGISTRATION FORM

NAME: _____ DATE: _____/_____/_____

ADDRESS: _____

CITY/STATE: _____ COUNTRY: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____/_____/_____ OCCUPATION: _____

☐ MALE ☐ FEMALE ☐ NON-BINARY/OTHER:

_____

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: _____
- ☐ FRIEND/RELATIVE NAME: _____
- ☐ REFERRING PHYSICIAN NAME: _____
- ☐ REFERRING EYE DOCTOR-NAME: _____
- ☐ COSMETIC OR EYE PLASTIC SURGERY WEBSITE: _____
- ☐ OTHER: _____

CURRENT OPHTHALMOLOGIST / OPTOMETRIST: _____

PRIMARY CARE PHYSICIAN: _____ ADDRESS: _____

IN CASE OF AN 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

THIS IS A DOUBLE SIDED DOCUMENT →

Katherine Lane, MD • 55 Timber Lane Medical Center • So. Burlington, VT 05403

Phone: (802) 864.2010 • Fax: (802) 864.1218 • vtcosmeticeyesurgery.com

VERMONT COSMETIC EYE SURGERY

COSMETIC PRE-TREATMENT QUESTIONNAIRE

NAME: _____ DATE: _____/_____/_____

MEDICAL HISTORY:

AUTOIMMUNE DISORDERS (RHEUMATOID ARTHRITIS, COLLAGEN VASCULAR DISEASE, SJOGREN'S SYNDROME, LUPUS)? ☐ **YES** ☐ **NO**
PIGMENTATION DISORDERS (VITILIGO, POST-INFLAMMATORY HYPERPIGMENTATION) ☐ **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

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**
DO YOU EVER HAVE SWELLING AROUND YOUR EYES AFTER SALTY MEALS? ☐ **YES** ☐ **NO**
DO YOU EVER HAVE SWELLING AROUND YOUR EYES 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:

_____

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, ETC.)**

THIS IS A DOUBLE SIDED DOCUMENT →

Katherine Lane, MD • 55 Timber Lane Medical Center • So. Burlington, VT 05403
Phone: (802) 864.2010 • Fax: (802) 864.1218 • vtcosmeticeyesurgery.com

VERMONT COSMETIC EYE SURGERY

☐ **GINKO** ☐ **GARLIC** ☐ **GREEN TEA**

PLEASE LIST ALL KNOWN ALLERGIES: _____

THIS IS A DOUBLE SIDED DOCUMENT →

Katherine Lane, MD • 55 Timber Lane Medical Center • So. Burlington, VT 05403

Phone: (802) 864.2010 • Fax: (802) 864.1218 • vtcosmeticeyesurgery.com