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 your suffer from cold sores?: Yes ☐ No ☐ _____

HIV: Yes ☐ No ☐

Please list all previous surgery with dates:

_____

_____

Surgery complications: _____

How did you find out about us?

☐ Website ☐ Facebook ☐Twitter ☐Instagram ☐Recommendation ☐GP/Specialist Referral

Procedures/Services of Interest:

_____

Questions to discuss: _____

_____

Important:

your problem have any Medical, Physical or Psychological basis? Yes ☐ No ☐

Sign:

_____

Patient Signature Date Relationship, if not patient

Responsible Clinician

_____

Mr M S C Murison Date

Last Date Edited: Tuesday, 21 February 2020