



John L. Porcaro, MD, FACS, FAACS
 1943 SE Port St. Lucie Blvd.
 Port St. Lucie, FL 34952

Patient Registration

(Please Print Clearly)

Patient Name: _____ Date: _____

Address: _____

Home phone: (____) _____ Cell phone: (____) _____ Work phone: (____) _____
 City State Zip

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

E-mail address: _____ Referred by: _____

How did you hear about us? _____

Married Widowed Single Separated Divorced Partnered for _____ yrs Minor

Spouse/Significant Other's Name: _____

Emergency contact person: _____ Phone number: (____) _____

Name of pharmacy: _____ Phone number: (____) _____

Occupation: _____

What is your main reason for visiting our office today? _____

Please note any of the following that you may be interested in:

- Lipotherme Laser Liposculpture Fat Transfer Tummy Tuck Hair Transplant Hormone Replacement
- Laser Hair Restoration Eyelid Surgery Face Lift Botox Restylane Juvederm
- Sculptra Sclerotherapy for varicose & spider vein Breast Augmentation Breast Lift Breast Reduction
- Male Breast Reduction Labiaplasty Vaginoplasty Laser Acne Treatments Laser Facial Rejuvenation
- Skincare Products Skincare Consultation Facial Peels Microdermabrasion Permanent make-up

May we contact you to remind you of upcoming appointments, or to reschedule/schedule missed or future appointments? YES NO

May we contact you regarding new services, products, or procedures we think you might be interested in? YES NO

Would you be interested in hearing about any seminars or other events our office will be hosting? YES NO

Do you prefer being contacted by phone or e-mail? Phone E-mail

If by phone, when is the best time to call you? _____

Which number do you prefer we use? Home Cell Work

Do we have your permission to leave a message on your voice mail, answering machine, or with the person who answers the phone? YES NO

Would you be interested in receiving special offers by e-mail from our office? YES NO

1. I acknowledge that for security purposes Porcaro Hair & Cosmetic Surgery may preserve any and all medical records and related documents by electronic scan and/or computerized means and that the original physical documents may be destroyed.
2. I agree that any and all electronic formats (i.e. scanned) shall have the same legal and medical effects as destroyed originals.

Patient Signature: _____ Date: _____

www.porcarosurgical.com

Please answer ALL the questions and fill in the blanks when indicated.

1. Are you in good health?			<input type="checkbox"/> Y <input type="checkbox"/> N
2. Your last physical examination was			
3. Are you under the care of a physician?			<input type="checkbox"/> Y <input type="checkbox"/> N
If so, what is the condition being treated?			
4.a What's your height now:	4.b What's your weight now:	4.c What's the most you ever weighed (including pregnancy):	
5. Have you had any serious illness or operation?			<input type="checkbox"/> Y <input type="checkbox"/> N
6. Have you been hospitalized or had a serious illness within the past five (5) years?			<input type="checkbox"/> Y <input type="checkbox"/> N
7. Do you drink alcoholic beverages NEVER SOCIALLY SOMETIMES REGULARLY			
8. Do YOU have, or have YOU had, any of the following diseases or problems?			
Rheumatic fever or rheumatic heart disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Low blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N
Kidney trouble; kidney failure	<input type="checkbox"/> Y <input type="checkbox"/> N	Venereal disease, genital herpes, STD, HIV, AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N
Cardiovascular disease - heart trouble, heart attack	<input type="checkbox"/> Y <input type="checkbox"/> N	High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N
Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke, TIA	<input type="checkbox"/> Y <input type="checkbox"/> N
Cardiac stents	<input type="checkbox"/> Y <input type="checkbox"/> N	Prosthetic joints or metal plates	<input type="checkbox"/> Y <input type="checkbox"/> N
Pain in your chest upon exertion? Palpitations?	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Recent upper respiratory tract infection?	<input type="checkbox"/> Y <input type="checkbox"/> N	Cancer, now or in the past	<input type="checkbox"/> Y <input type="checkbox"/> N
Are you short of breath after mild exercise?	<input type="checkbox"/> Y <input type="checkbox"/> N	Cold Sores/fever blisters/shingles/herpes	<input type="checkbox"/> Y <input type="checkbox"/> N
Difficult Airway?	<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma, Cataracts, Dry eyes	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you get short of breath when you lie down or do you require extra pillows for sleep?	<input type="checkbox"/> Y <input type="checkbox"/> N	High cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N
		Thyroid disorder	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma, COPD, emphysema, bronchitis, cough	<input type="checkbox"/> Y <input type="checkbox"/> N	Smoker	<input type="checkbox"/> Y <input type="checkbox"/> N
Influenza (recent flu)	<input type="checkbox"/> Y <input type="checkbox"/> N	Presently using nicotine patches	<input type="checkbox"/> Y <input type="checkbox"/> N
Hives, skin rash, eczema, hay fever, acne	<input type="checkbox"/> Y <input type="checkbox"/> N	Chemical dependency	<input type="checkbox"/> Y <input type="checkbox"/> N
Fainting spells, seizures, epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Collagen/Vascular disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Psychiatric problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you urinate more than 6 (six) times per day?	<input type="checkbox"/> Y <input type="checkbox"/> N	Recent weight loss/eating disorder	<input type="checkbox"/> Y <input type="checkbox"/> N
Are you thirsty much of the day?	<input type="checkbox"/> Y <input type="checkbox"/> N	Heal poorly/form keloids	<input type="checkbox"/> Y <input type="checkbox"/> N
Dry eyes, prior eye surgery, contact lenses?	<input type="checkbox"/> Y <input type="checkbox"/> N	Curvature of the spine	<input type="checkbox"/> Y <input type="checkbox"/> N
Lupus	<input type="checkbox"/> Y <input type="checkbox"/> N	Prior complications with anesthesia during surgery	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N	Refused as a blood donor	<input type="checkbox"/> Y <input type="checkbox"/> N
Inflammatory rheumatism (painful swollen joints)	<input type="checkbox"/> Y <input type="checkbox"/> N	History of blood clots or pulmonary embolus	<input type="checkbox"/> Y <input type="checkbox"/> N
Stomach ulcers, hiatal, hernia, reflux, aspiration risk	<input type="checkbox"/> Y <input type="checkbox"/> N	Edema/Lymphedema	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you have any blood disorders such as anemia or hemophilia?	<input type="checkbox"/> Y <input type="checkbox"/> N	Abnormal bleeding associated with previous tooth extractions, surgery or trauma?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you bruise easily?	<input type="checkbox"/> Y <input type="checkbox"/> N	Infection; hemorrhage	<input type="checkbox"/> Y <input type="checkbox"/> N
Have you ever required a blood transfusion?	<input type="checkbox"/> Y <input type="checkbox"/> N	Unexplained weight loss or gain	<input type="checkbox"/> Y <input type="checkbox"/> N
Hepatitis A, B or C	<input type="checkbox"/> Y <input type="checkbox"/> N	Removed spleen	<input type="checkbox"/> Y <input type="checkbox"/> N
Liver disorder/Immune disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Varicose Veins, swollen legs; ankles	<input type="checkbox"/> Y <input type="checkbox"/> N
Inflammatory Bowel Disease; Crohn's	<input type="checkbox"/> Y <input type="checkbox"/> N	Depression	<input type="checkbox"/> Y <input type="checkbox"/> N
Anxiety, phobias	<input type="checkbox"/> Y <input type="checkbox"/> N	Bipolar, Schizophrenia	<input type="checkbox"/> Y <input type="checkbox"/> N
Which best describes your usual emotional state:		Do you have, or have you ever had problems with:	
Happy	<input type="checkbox"/> Y <input type="checkbox"/> N	Nervousness, tension, feeling down or Blue?	<input type="checkbox"/> Y <input type="checkbox"/> N
Reserved	<input type="checkbox"/> Y <input type="checkbox"/> N	History of a nervous breakdown?	<input type="checkbox"/> Y <input type="checkbox"/> N
Excited	<input type="checkbox"/> Y <input type="checkbox"/> N	History of counseling or psychiatric treatment?	<input type="checkbox"/> Y <input type="checkbox"/> N
Distressed	<input type="checkbox"/> Y <input type="checkbox"/> N	Has your weight been stable for the last 6 months?	<input type="checkbox"/> Y <input type="checkbox"/> N
Pleasant	<input type="checkbox"/> Y <input type="checkbox"/> N		
Anxious	<input type="checkbox"/> Y <input type="checkbox"/> N		
Depressed	<input type="checkbox"/> Y <input type="checkbox"/> N		

Please explain all "Yes" responses and diseases, conditions or problems not listed: _____

<p>9. Are YOU taking any of the following?</p> <p>Antibiotics or sulfa drugs Anticoagulants (blood thinners) Medicine for high blood pressure Tranquilizers Cortisone (steroids) within last 6 mos. Aspirin Insulin, tolbutamide (Orinase) or similar drugs Nitroglycerin Drugs for heart trouble Chemotherapy Home Oxygen Accutane within past 6 mos. Other: _____ _____</p>	<p><input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N</p>	<p>10. Are YOU allergic or have you reacted adversely in any way to the following?</p> <p>Local anesthetics Penicillin or other antibiotics Sulfa drugs Aspirin Iodine Latex Barbiturates, sedatives or sleeping pills Other _____ _____ _____ _____</p>	<p><input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>Y <input type="checkbox"/>N</p>
---	--	---	--

Please list ALL drugs, medications, prescription and over the counter, vitamins, minerals, supplements, including herbal supplements YOU are taking including frequency and dosage:

11. FAMILY HISTORY: Have any of YOUR blood relatives ever had the following problems:

Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N	Coronary Surgery	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Abnormal Clotting	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Anesthetic Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N	Other Serious Illness	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N	Breast Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N

Please describe all "Yes" answers: _____

12. FOR WOMEN:

Pregnant or could be pregnant	<input type="checkbox"/> Y <input type="checkbox"/> N	Tubal ligation	<input type="checkbox"/> Y <input type="checkbox"/> N
Taking birth control pills	<input type="checkbox"/> Y <input type="checkbox"/> N	Taking hormone replacement at this time	<input type="checkbox"/> Y <input type="checkbox"/> N
Number of pregnancies		Polycystic ovaries	<input type="checkbox"/> Y <input type="checkbox"/> N
Ovarian, adrenal, pituitary problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Mammogram within 1 yr	<input type="checkbox"/> Y <input type="checkbox"/> N
Hereditary problems of breast cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Breast biopsies	<input type="checkbox"/> Y <input type="checkbox"/> N
Satisfied sex life	<input type="checkbox"/> Y <input type="checkbox"/> N	Hysterectomy	<input type="checkbox"/> Y <input type="checkbox"/> N
Pap smear within 1 year	<input type="checkbox"/> Y <input type="checkbox"/> N	Sexually active	<input type="checkbox"/> Y <input type="checkbox"/> N
Number of children		Cesarean Section	<input type="checkbox"/> Y <input type="checkbox"/> N
Last menstrual period		Have periods stopped?	<input type="checkbox"/> Y <input type="checkbox"/> N
Sleep disruption/Insomnia	<input type="checkbox"/> Y <input type="checkbox"/> N	Fatigue	<input type="checkbox"/> Y <input type="checkbox"/> N
Short term memory loss/ Foggy Thinking	<input type="checkbox"/> Y <input type="checkbox"/> N	Weight gain	<input type="checkbox"/> Y <input type="checkbox"/> N

FOR WOMEN (cont.)

Hot flashes/Menopausal symptoms	<input type="checkbox"/> Y <input type="checkbox"/> N	Decreased sex drive	<input type="checkbox"/> Y <input type="checkbox"/> N
Vaginal dryness	<input type="checkbox"/> Y <input type="checkbox"/> N	Depression	<input type="checkbox"/> Y <input type="checkbox"/> N
Irritability	<input type="checkbox"/> Y <input type="checkbox"/> N	Bladder symptoms	<input type="checkbox"/> Y <input type="checkbox"/> N
Nervousness	<input type="checkbox"/> Y <input type="checkbox"/> N	Night sweats	<input type="checkbox"/> Y <input type="checkbox"/> N
Harder to reach climax	<input type="checkbox"/> Y <input type="checkbox"/> N	Breast tenderness	<input type="checkbox"/> Y <input type="checkbox"/> N
Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Hair loss	<input type="checkbox"/> Y <input type="checkbox"/> N
PMS symptoms	<input type="checkbox"/> Y <input type="checkbox"/> N	Menstrual migraines	<input type="checkbox"/> Y <input type="checkbox"/> N
Osteoporosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Chronic fatigue syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N
Fibromyalgia	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have any bleeding between periods?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you have any cramping with your periods?	<input type="checkbox"/> Y <input type="checkbox"/> N	How many days does your period last?	
Are/were YOUR periods regular?	<input type="checkbox"/> Y <input type="checkbox"/> N	Could you have a hormone deficiency?	<input type="checkbox"/> Y <input type="checkbox"/> N

13. FOR MEN:

Fatigue	<input type="checkbox"/> Y <input type="checkbox"/> N	Short term memory loss/ Foggy Thinking	<input type="checkbox"/> Y <input type="checkbox"/> N
Decreased energy level	<input type="checkbox"/> Y <input type="checkbox"/> N	Decreased sex drive	<input type="checkbox"/> Y <input type="checkbox"/> N
Anxiety	<input type="checkbox"/> Y <input type="checkbox"/> N	Irritability	<input type="checkbox"/> Y <input type="checkbox"/> N
Depression	<input type="checkbox"/> Y <input type="checkbox"/> N	Loss of muscle mass	<input type="checkbox"/> Y <input type="checkbox"/> N
Mood swings	<input type="checkbox"/> Y <input type="checkbox"/> N	Migraines	<input type="checkbox"/> Y <input type="checkbox"/> N
Prostate cancer/ Prostate Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Erectile dysfunction/Easy to loose erection	<input type="checkbox"/> Y <input type="checkbox"/> N
Premature ejaculation	<input type="checkbox"/> Y <input type="checkbox"/> N	Satisfying sex life	<input type="checkbox"/> Y <input type="checkbox"/> N
PSA in last year	<input type="checkbox"/> Y <input type="checkbox"/> N	Used Steroids	<input type="checkbox"/> Y <input type="checkbox"/> N
Sleep Disruption/ Insomnia	<input type="checkbox"/> Y <input type="checkbox"/> N	Could you have a Hormone Deficiency?	<input type="checkbox"/> Y <input type="checkbox"/> N
Number of children fathered	_____	Taking Hormones at this time?	<input type="checkbox"/> Y <input type="checkbox"/> N

Comments: _____

14. List your Non-cosmetic surgeries (i.e. Appendectomy, Gallbladder, Hysterectomy, Cesarean Section, Tubal Sterilization, Lasix, Cataract Surgery) and dates: _____

15. List your Cosmetic surgeries (i.e. Face lift, Eyelid lift, Breast augmentation, Tummy tuck, Liposuction) and Dates: _____

16. List your Botox, Restylane, Juvederm, Sculptra, Silicone Injections, etc. and dates:

17. I acknowledge that it is my responsibility to accurately inform Dr. John L. Porcaro of any medications, medical history or information possibly relevant to my treatment and/or surgery. Any misinformation, purposeful or otherwise may lead to improper treatment and potentially adverse reactions to proposed medications. Any purposeful misinformation related to the information presented in this record may result in termination of the doctor patient relationship and any care with Porcaro Hair & Cosmetic Surgery. By signing below, I acknowledge that the information I provided regarding my medical history is correct and I will keep this information up to date by informing the office of any change in my medications or in my health.

18. I acknowledge that I have reviewed a copy of "Porcaro Financial Policy" and by signing below I understand and agree to comply with the Financial Policy.

19. I acknowledge that I have had the chance to review a copy of "Porcaro Notice of Privacy Practices"

Patient Signature: X	Date
Doctor's Notes:	
Dr. Porcaro's Signature	Date