sharon giese, md

BOARD CERTIFIED PLASTIC SURGEON

Patient Registration Form

Today's Date: ___/___/______

Name: ______________________________ Age: ______ DOB: ___ /___ /______

Name by which you prefer to be addressed by office staff ______________________________

Home Address: ______________________________
(Street) (Apt.)

____
(City) (State) (Zip Code)

Home phone: (___) __________ Business phone: (___) __________ Cell phone: (___) __________

Email: ______________________________

If visiting NY, Local Address ______________________ Phone: (___) __________

Occupation: ______________________ Employer: ______________________

Business Address: ______________________________

Contact in case of emergency ______________________________
(Name) (Phone)

Pharmacy: ______________ Address: ______________ Phone: (___) __________

How did you hear about Dr. Giese? ______________________________

Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply.

- ☐ Cellulite
- ☐ Breast Size/shape
- ☐ Abdominal Area
- ☐ Body Contouring
- ☐ Hips/Legs
- ☐ Facial Contouring
- ☐ Facial Fullness/Redness
- ☐ Jowls
- ☐ Drooping Brow
- ☐ Drooping Eyelids
- ☐ Dark Under Eye Circles
- ☐ Neck Wrinkles
- ☐ Brown Spots/Age spots/Freckles
- ☐ Skin Care Products
- ☐ Facial Fullness/Drooping
- ☐ Injectable Treatments
- ☐ Thin Lips
- ☐ Juvederm/Restylane/Radiesse
- ☐ Fine Lines/Wrinkles
- ☐ Chemical Peel
- ☐ Crepey Hands/Knees/Elbows/Stomach
- ☐ Length/Fullness Of Eyelashes
- ☐ Urine Leakage
- ☐ Pain During Intercourse
- ☐ Vaginal Dryness
- ☐ Vaginal Rejuvenation

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Medical History

Height:____ feet ____ inches Weight:____ pounds
Marital Status: ______ Number of Children:____ Ages of Children: ______________________________
The reason for my visit is: ______________________________
Prior Plastic Surgery History: Please check here if none: ☐ Otherwise, please list below:
1)____________________ date: ________ 2)____________________ date: ____________
3)____________________ date: ________ 4)____________________ date: ____________
Other: ______________________________
Current Medication(s): Please check here if none: ☐ Otherwise, please list below:
1)____________________ 2)____________________ 3)____________________
4)____________________ 5)____________________ 6)____________________
Herbal Medications: ______________________________
Previous Medical Operation(s): Please check here if none: ☐ Otherwise, please list below:
1)____________________ date: ________ 2)____________________ date: ____________
3)____________________ date: ________ 4)____________________ date: ____________
Any history of trouble with anesthesia ______________________________

Medical Problems (Please Check Where Appropriate): Please check here if none: ☐
☐ Diabetes ☐ High Blood Pressure ☐ Heart ☐ Kidney ☐ Digestive ☐ Muscle/Bone ☐ Skin ☐ Nervous System
Describe/Others: ______________________________
Drug Allergies: None ☐ 1)________________ 2)________________ 3)________________
Do you bleed easily? Yes ☐ No ☐
Do you smoke? Yes ☐ No ☐
If yes, how much? ________ For how many years? ________ How long since your last cigarette? _______
Alcohol Consumption: Never ☐ Rarely ☐ Occasionally ☐ Often ☐
History of Eating Disorders: ______________________________
Do you see a psychiatrist? Yes ☐ No ☐ If yes, how many times per week: ________
Are you taking any antidepressants? Yes ☐ No ☐
Any history of drug use, including marijuana______________________________
Current Physicians Address/Location:
1)____________________ ____________________
2)____________________ ____________________
3)____________________ ____________________
Above information truthful and complete:______________________________
Signature

114 East 61st Street New York, N.Y. 10065