Suzanne A. Trott, M.D.
462 N. Linden Dr. suite 240
Beverly Hills, Ca 90212

DATE: _____

PATIENT REGISTRATION

_____ _____
PATIENT NAME **BIRTH DATE**

_____ _____ _____ **SEX: M / F**
AGE **SOCIAL SECURITY NUMBER** **MARITAL STATUS**

_____
HOME ADDRESS **CITY** **STATE** **ZIP CODE**

_____ _____
HOME PHONE **CELL PHONE**

_____ _____
BUSINESS PHONE **FAX**

_____ _____
E-MAIL ADDRESS **OCCUPATION**

_____
EMERGENCY CONTACT **EMERGENCY CONTACT'S PHONE NUMBER**

HOW DID YOU HEAR ABOUT DR TROTT? _____

WHAT PROCEDURES ARE YOU INTERESTED IN, IN ORDER OF IMPORTANCE?

_____

_____

_____

WHEN ARE YOU PLANNING TO HAVE SURGERY? _____

HEALTH HISTORY

CONFIDENTIAL RECORD: INFORMATION CONTAINED HERE WILL NOT BE RELEASED EXCEPT WHEN YOU HAVE AUTHORIZED US TO DO SO. PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. THE INFORMATION PROVIDED BY YOU WILL BE USED BY YOUR DOCTOR IN HER DECISION REGARDING YOUR CASE.

PRIMARY PHYSICIAN: _____

ADDRESS: _____ **PHONE:** _____

ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS OR MATERIALS? WHICH? WHAT ARE YOUR SYMPTOMS? _____

_____

HEIGHT: _____ **WEIGHT:** _____

GENERAL HEALTH: EXCELLENT _____ **GOOD** _____ **FAIR** _____ **POOR** _____

SPECIFIC CONDITIONS: HAVE YOU HAD OR HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? IF SO CIRCLE, EXPLAIN AND GIVE DATES OF OCCURANCE(S) BELOW.

CANCER
DIABETES
BLURRED VISION
OTHER EYE PROBLEMS
HEARING DIFFICULTY
DEAFNESS
SINUS TROUBLE
DIFFICULTY WITH BALANCE
SEVERE HEADACHES
EAR PAIN
HAY FEVER
TONSILLITIS
GLAUCOMA
EPILEPSY
RHEUMATIC HEART
BLEEDING TENDENCY
HIGH BLOOD PRESSURE
CONGENITAL HEART
ANEMIA
SHORTNESS OF BREATH
UNUSUAL HEARTBEAT
CHEST PAIN
HEPATITIS
COLITIS
STOMACH ULCERS
BLADDER INFECTION
PREGNANT
BREAST LUMP
DISCHAGE FROM NIPPLES
OTHER BREAST PROBLEMS
RECENT WEIGHT LOSS
RECENT WEIGHT GAIN
THIRSTY ALL THE TIME
OFTEN DEPRESSED
FAINTING SPELLS
NERVOUS BREAKDOWN
ASTHMA
MENOPAUSE

EXPLAIN: _____

_____

HEALTH HISTORY CONTINUED

WHAT IS YOUR APPROXIMATE DAILY CONSUMPTION OF THE FOLLOWING?

COFFEE/TEA: _____ TOBACCO: _____ ALCOHOL: _____ OTHER: _____

PLEASE CIRCLE YES OR NO IF TAKING A MEDICATION FOR THE FOLLOWING

ASPIRIN, BUFFERIN, ANACIN	**NO/YES**	**BLOOD THINNING PILLS**	**NO/YES**
BLOOD PRESSURE PILLS	**NO/YES**	**DILANTIN**	**NO/YES**
CORTISONE-STERIODS	**NO/YES**	**SHOTS**	**NO/YES**
COUGH MEDICINE	**NO/YES**	**WATER PILLS**	**NO/YES**
DIGITALIS	**NO/YES**	**ANTIBIOTICS**	**NO/YES**
HORMONES	**NO/YES**	**BARBITUATES**	**NO/YES**
INSULIN OR DIABETIC PILLS	**NO/YES**	**BIRTH CONTROL PILLS**	**NO/YES**
IRON OR TIRED BLOOD MEDICATIONS	**NO/YES**	**PHENOBARBITAL**	**NO/YES**
LAXATIVES	**NO/YES**	**OTHER DRUGS NOT LISTED**	**NO/YES**
SLEEPING PILLS	**NO/YES**	**THYROID MEDICATION**	**NO/YES**
HEADACHE PILLS	**NO/YES**	**MEDICINE FOR ARTHRITIS**	**NO/YES**
TRANQUILIZERS	**NO/YES**	**WEIGHT REDUCING PILLS**	**NO/YES**
VITAMIN E	**NO/YES**	**VITAMIN A**	**NO/YES**
VITAMIN B	**NO/YES**	**VITAMIN C**	**NO/YES**
HERBALS	**NO/YES**		

SPECIFY AND LIST ANY OTHER DRUG YOU ARE TAKING: _____

_____

_____

PERTINENT PRE-OPERATIVE INFORMATION:
HAVE YOU OR ANY FAMILY MEMBERS REACTED POORLY TO BEING PUT TO SLEEP? NO/YES

IF YES, HOW? _____

_____

HAVE YOU REQUIRED UNUSUALLY LARGER OR SMALLER
AMOUNTS OF ANESTHESIA FOR MEDICAL OR DENTAL PROCEDURES? NO/YES
HAVE YOU EVER HAD A BAD REACTION TO A LOCAL ANESTETIC (NOVOCAIN ETC.)? NO/YES
ARE YOU ALLERGIC TO ADHESIVE TAPE? NO/YES
DO YOU HAVE HIGH BLOOD PRESSURE? NO/YES
DO YOU BLEED OR BRUISE EASILY FROM CUTS OR SURGERY NO/YES
DOES YOUR RELIGION PROHIBIT BLOOD TRANFUSIONS? NO/YES

_____ _____

PATIENT SIGNATURE **DATE**

PHOTOGRAPHIC IMAGE RELEASE FOR ADVERTISING AND FOR USE ON THE INTERNET

I, _____, HEREBY AUTHORIZE DR SUZANNE A. TROTT TO USE MY PRE AND POST OPERATIVE PICTURES, (NO NAMES OR FACES) FOR ADVERTISING PURPOSES. THIS WOULD INCLUDE USE IN PRINT ADS, BROCHURES, A PICTURE BOOK FOR NEW PATIENTS TO LOOK THROUGH AND ON HER WEBSITE.

I UNDERSTAND THAT THE WEBSITE IS ACCESSIBLE BY THE GENERAL PUBLIC, AND THAT DR TROTT SHALL NOT BE RESPONSIBLE FOR ANY USE OF MY IMAGE BY INDIVIDUALS ACCESSING THE WEBSITE. IF AT A LATER DATE, I INDICATE IN WRITING THAT I WOULD LIKE MY IMAGE TO BE WITHDRAWN FROM THE WEBSITE, DR SUZANNE TROTT AGREES TO DO SO WITHIN SIXTY DAYS FROM THE RECEIPT OF MY REQUEST. DR SUZANNE TROTT MAY REMOVE MY PHOTOGRAPHIC IMAGE FROM THE WEBSITE AT HER SOLE DISCRETION.

I ALSO AUTHORIZE DR TROTT TO SHOW MY PRE AND POST OPERATIVE PICTURES TO THE AMERICAN BOARD OF PLASTIC SURGERY.

_____ _____

PRINTED NAME **DATE**

_____

SIGNATURE

_____ _____

WITNESS **DATE**