YOUNGER IMAGE
Plastic Surgery Center

Jamal Yousefi, M.D.
Board Certified Plastic Surgeon
Diplomat of American Society of Plastic Surgeons

AMERICAN SOCIETY OF PLASTIC SURGEONS

PATIENT REGISTRATION & MEDICAL INFORMATION

(Please Print Legibly & Fill In All Fields)

TODAY'S DATE: _____

Patient's Name: _____
First Middle Last

Address: _____
Street & Apt # City State Zip Code

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email: _____ **Any restrictions for contacting you?** ❒ No ❒ Yes

If Yes, Specify Restrictions: _____

Age: _____ **Birthdate:** _____ **SS#:** _____ **Gender:** ❒Female ❒Male

Marital Status: ❒ Single ❒ Married ❒ Widowed ❒ Divorced

Employer: _____ **Occupation:** _____

Emergency Contact Name : _____ **Emergency Phone:** _____

Relationship to the Patient: _____

AREAS OF INTEREST: *(Mark all that apply)*

Breast Procedures
- ❒ Breast Augmentation
- ❒ Breast Reduction
- ❒ Breast Mastopexy (Breast Lift)
- ❒ Nipple Reduction or Inversion
- ❒ Fat Transfer to Breast

Facial Procedures
- ❒ Earlobe Repair
- ❒ Facial Liposuction (Neck, Jowls)
- ❒ Lip Enhancement
- ❒ Blepharoplasty (Eyelid Lift)
- ❒ Brow or Forehead Lift
- ❒ Face or Neck Lift
- ❒ Otoplasty (Ear Pinning)
- ❒ Rhinoplasty (Nose Reshaping)

Body Procedures
- ❒ Abdominoplasty (Tummy Tuck)
- ❒ Brachioplasty (Arm Lift)
- ❒ Liposuction (Thighs, Abdomen, Etc.)
- ❒ Thigh or Buttock Lift
- ❒ Full Body Lift
- ❒ Fat Transfer to Buttocks
- ❒ Laser Hair Removal
- ❒ Skin Resurfacing (Laser, Peel, Etc.)
- ❒ Lesions / Moles
- ❒ Microdermabrasion
- ❒ Acne
- ❒ Skin Care
- ❒ Hair Transplantation
- ❒ Microneedling

Injections
- ❒ Botox/Dysport
- ❒ Fillers

HOW LONG HAS THIS BEEN BOTHERING YOU? _____

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GENERAL HEALTH: ❒ GOOD ❒ FAIR ❒ POOR **HEIGHT:** _____ **WEIGHT:** _____

PLEASE CHECK ANY OF THE FOLLOWING MEDICAL ILLNESSES THAT YOU MAY HAVE:

___High Blood Pressure
___Diabetics (Type _____)
___Heart Problem
___Breathing Problem
___Kidney Problem
___Complications from Anesthesia
___Stomach Problems
___Bleeding Problems
___Thyroid Problems
___Mental Illness
___Keloids or Hypertopic Scars
___Cancer
___Anemia
___Eye Problems
___Neurological Disorders
___Rheumatic Fever
___Ulcer
___Mitral Valve Prolapse
___Fever Blister/Cold Sores

WHEN WERE YOU LAST TESTED FOR HIV? _____ **POSITIVE/NEGATIVE RESULT?** _____

DO YOU HAVE ANY PSYCHIATRIC ISSUES? ❒ No ❒ Yes **If YES, Please Explain:** _____

HAVE YOU EVER HAD ANY SURGERIES BEFORE? ❒No ❒Yes **If YES, Please List Surgery Type and Date of Surgery:**

_____

HAVE YOU HAD ANY REACTION TO INJECTIONS OF LOCAL ANESTHESIA? ❒ No ❒ Yes

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? ***(Including Multi-Vitamins and Supplements)***

_____

_____

DO YOU TAKE ASPIRIN, VITAMIN 'E', OR ANY BLOOD THINNER? ❒ No ❒ Yes

DO YOU HAVE ALLERGIES TO ANY MEDICATIONS? ❒ No ❒ Yes **If YES, Please List:** _____

_____

DO YOU SMOKE? ❒ No ❒ Yes

If YES, How often do you smoke?_____ **How long have you been smoking for?** _____

HOW OFTEN DO YOU DRINK ALCOHOL?_____

ARE YOU PREGNANT OR LACTATING? ❒ No ❒ Yes

DO YOU HAVE A PRIMARY CARE PHYSICIAN? ❒ No ❒ Yes

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HOW DID YOU HEAR ABOUT OUR OFFICE? *(Mark all that apply)*

❒ Groupon ❒ Google ❒ Magazine ❒Seminar ❒ Facebook ❒ Website ❒ Sign/Drive-by ❒ Instagram ❒ Doctor: _____

❒ Friend/Relative/Previous Patient: _____ ❒ Other: _____

WOULD YOU LIKE A COMPLIMENTARY SKIN CARE EVALUATION WITH OUR ESTHETICIAN? ❒ No ❒ Yes

IF YES, PLEASE COMPLETE BELOW:

DO YOU EXPERIENCE SKIN BREAK OUTS? ❒ No ❒ Yes **If YES, how often?** _____

IS YOUR SKIN: ❒ Dry ❒ Oily ❒ Normal ❒ Sensitive ❒ Acne Prone

DO YOU HAVE ANY PIGMENTATION PROBLEMS? ❒ No ❒ Yes

DO YOU HAVE A HISTORY OF ACCUTANE THERAPY? ❒ No ❒ Yes

DO YOU HAVE A HISTORY OF FEVER BLISTERS OR COLD SORES? ❒ No ❒ Yes

HAVE YOU EVERY HAD A FACIAL PEEL? ❒ No ❒ Yes

DO YOU HAVE A HISTORY OF SCARRING? ❒ No ❒ Yes **KELOIDS?** ❒ No ❒ Yes

HAVE YOU HAD ANY OF THE FOLLOWING? *(Mark all that apply)* ❒ Recent waxing ❒ Electrolysis ❒ Laser ❒ Sun exposure

WHAT IMPROVEMENTS WOULD YOU LIKE TO SEE IN YOUR SKIN? _____

_____

_____ _____

PATIENT SIGNATURE **TODAY'S DATE**