John Q. Cook, M.D.

WHOLE BEAUTY®

737 N Michigan Ave., Suite 760
Chicago, Il 60611
(312) 751-2112

118 Green Bay Road
Winnetka, Il 60093
(847) 446-7562

PATIENT REGISTRATION AND CONSENT FOR TREATMENT FORM

PATIENT INFORMATION

MR/MRS/MS/DR _____ PREFERRED FIRST NAME _____ ☐MALE ☐FEMALE

FIRST NAME _____ M.I. _____ LAST NAME _____

ADDRESS _____ APT. _____

CITY _____ STATE _____ ZIP _____

HOME PHONE ( ) _____ MIOBILE PHONE ( ) _____ E-MAIL ADDRESS _____

BIRTH DATE _____

☐SINGLE ☐MARRIED ☐OTHER _____

☐ I WOULD LIKE TO SUBSCRIBE TO DR. COOK'S BLOG AND NEWSLETTER ABOUT ADVANCES IN PLASTIC SURGERY

☐ I WOULD LIKE TO RECEIVE UPDATES ON TREATMENT AND PRODUCT PROMOTIONS AT THE WHOLE BEAUTY INSITITUTE

DID YOU VISIT OUR WEBSITE AT WWW.JOHNQCOOKMD.COM? ☐ YES ☐ NO

REFERRAL INFORMATION

☐REFERRED BY PATIENT ☐REFERRED BY PHYSICIAN

REFERRAL SOURCE 1 NAME _____

ADDRESS (IF AVAILABLE) _____

CITY _____ STATE _____ ZIP _____

☐REFERRED BY PATIENT ☐REFERRED BY PHYSICIAN

REFERRAL SOURCE 2 NAME _____

ADDRESS (IF AVAILABLE) _____

CITY _____ STATE _____ ZIP _____

PRIMARY CARE PHYSICIAN NAME _____

EMERGENCY CONTACT

FIRST NAME LAST NAME

RELATIONSHIP

( )
MOBILE PHONE

E-MAIL ADDRESS

SPOUSE

FIRST NAME LAST NAME

SPOUSE'S EMPLOYER

( )
SPOUSE'S MOBILE PHONE

EMPLOYMENT INFORMATION

☐ FULL TIME ☐ FULL TIME STUDENT ☐ RETIRED ☐ PART TIME ☐ PART TIME STUDENT ☐ OTHER

OCCUPATION COMPANY OR SCHOOL

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME NAME OF INSURED

ADDRESS CITY STATE ZIP

( )
PHONE POLICY # GROUP #

*I authorize **John Q. Cook, MD** to furnish information on conditions he has treated me for to my insurance carrier. I assign to Dr. Cook all payments for medical services rendered by him for me or my dependents. I understand that I am responsible for any amount billed and not covered by my insurance. A photocopy of this authorization and assignment is considered as valid as the original.*

SIGNED (PATIENT OR PARENT IF MINOR) DATE

*I hereby authorize **John Q. Cook, M.D.** to release any information acquired in the course of my examination or treatment.*

SIGNED (PATIENT OR PARENT IF MINOR) DATE

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MEDICAL HISTORY

PATIENT NAME: _____

What type of plastic surgery are you interested in discussing? _____

Who referred you to me? _____
May I send a thank-you letter to them? _____ ◯YES ◯NO

-Do you know anyone who has undergone the procedure you are interested in? _____ ◯YES ◯NO

-Have you done any reading about the procedure you are interested in? _____ ◯YES ◯NO

-Have you ever had a plastic surgery procedure before? _____ ◯YES ◯NO

if yes, please describe the type of surgery you had and your experience: _____

_____

_____

-Have you ever undergone surgery? _____ ◯YES ◯NO

If yes, please list previous surgeries and the approximate date: _____

_____

_____

-Did you have any unusual experiences after previous surgery, such as bleeding, reactions to medications, prolonged hospitalization or any departure from the expected postoperative course? _____ ◯YES ◯NO

--If you have had previous surgery, did any medications make you nauseated? _____ ◯YES ◯NO

If yes, please list them. _____

_____

_____

-Please list any medications you are currently taking and the reason you are taking them:

_____

_____

-Please list any pain medications which work well for you. (Those that relieve pain and do not make you nauseated):

_____

_____

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-Are you allergic to or have a sensitivity to any medication?_____ ◯YES ◯NO

If yes, describe the medication and the type of reaction. Airway obstruction?: _____

-Have you ever been diagnosed with sleep apnea? ◯YES ◯NO

-Have you ever had an allergy to Latex? ◯YES ◯NO

-Did you ever have an unusual reaction to anesthesia? ◯YES ◯NO

-Is there a family history of unusual reaction to anesthesia? ◯YES ◯NO
(such as malignant hyperthermia)? ◯YES ◯NO

-Do you have a history of nausea from pain medication? ◯YES ◯NO

-Do you have any unusual reactions with other medications? ◯YES ◯NO

-Do you get lightheaded or faint when giving blood? ◯YES ◯NO

-Do you get car sick or motion sickness easily? ◯YES ◯NO

-Do you experience lightheadedness after meals? ◯YES ◯NO

-Are you apprehensive or nervous about medical procedures? ◯YES ◯NO

-Does your dentist have a hard time blocking your nerves for dental procedures,
where multiple injections are required before you feel numb? ◯YES ◯NO

-Do you have any of the following medical conditions or any past history of these conditions?

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YES	NO	
◯	◯	Arthritis
◯	◯	Asthma or other lung disease
◯	◯	Pulmonary Embolism
◯	◯	Autoimmune Disease
◯	◯	Bleeding disorder
◯	◯	Blood Clots in Legs
◯	◯	C.Diff or Antibiotic Associated Diarrhea
◯	◯	Chest Pain
◯	◯	Diabetes
◯	◯	Depression
◯	◯	Easy bruising
◯	◯	Heart failure or other heart problems
◯	◯	High Blood Pressure
◯	◯	HIV or other immune deficiency
◯	◯	Low Blood Sugar
◯	◯	Lupus
◯	◯	Mitral valve prolapse
◯	◯	Polio
◯	◯	Rheumatic Fever
◯	◯	Scleroderma
◯	◯	Shortness of breath
◯	◯	Substance abuse
◯	◯	Thyroid disease
◯	◯	TMJ (Temporo-Mandibular Joint)
◯	◯	Other Psychiatric Disorders

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Do you have any other medical conditions which regularly bring you to a doctor? _____ YES NO
If yes, please list them:

_____

_____

-Do you smoke cigarettes or have a history of regular smoking in the past year? _____ YES NO
If yes, how many per day? _____

-Do you drink alcohol? _____ YES NO
If yes, what is the frequency? (number per day, week or month)? _____

-Do you take large doses of any vitamins (especially vitamins A or E)? _____ YES NO

-Have you in the past 12 months taken the drug Acutane or estrogens? _____ YES NO

-Do you have a tendency to form keloids, hypertrophic, thick scars or dark spots around surgical incisions or areas of injury? _____ YES NO

-Do you take aspirin, aspirin-like compounds?
(Motrin, Advil, Nuprin, Ibuprofen, Naprosyn, etc.) or aspirin containing preparations _____ YES NO
(Bufferin, Anacin, Excedrin, Dristan, Midol, Empirin, Alka Selzer, Fiorinal, Perdocan)? _____ YES NO
If yes, please describe how frequently:

_____

-Are you currently on or have been on the human chorionic gonadotropin diet or HCG diet _____ Yes No
If you were on this diet..how long ago?

_____

-What is your: HEIGHT_____ WEIGHT_____

-Name of Family Physician or Internist: _____
Date of last visit: _____
-Name of Obstetrician/Gynecologist: _____
Date of last visit: _____
-What is your occupation? _____
-What are your interests and hobbies? _____

To the best of my knowledge the above information is correct. I realize that by giving false information on this questionnaire may adversely affect the care I receive from Dr. Cook.

_____ _____
Signature *Date*

_____ _____
Print Name *Date of Birth*

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