

The Jasin Facial Rejuvenation Institute

Michael E Jasin M.D. P.A.
13801 Bruce B. Downs Blvd., Suite 305
Tampa, Florida 33613
(813) 975-3223

Patient Information

Patient Name _____ Date _____

Soc. Sec # _____ - _____ - _____ Driver license # _____

Birthdate: ____/____/____ Age: ____ Sex: ____ Marital Status: ____ Race: _____

Home Phone # (____) _____ - _____ Work# (____) _____ - _____ Ext: _____
(May we contact you at work?) yes no

Cell Phone # (____) _____ - _____

Fax # (____) _____ - _____ E- Mail : _____

Best Contact Method: () Cell () Home () Work () Email () Mail

Local Address: _____

City _____ State _____ Zip _____

During which months do you typically reside in the area? _____

Permanent Address: _____ Apt# _____

City _____ State _____ Zip _____

Patient Employer: _____ Occupation _____

Spouse's Name: _____ Employer: _____ Phone: _____

In case of an emergency, please list a LOCAL family member, neighbor, friend, we may contact

(Please list someone other than your spouse listed above) _____

Relation: _____ Phone: (____) _____

How were you referred to our office?:

() St. Pete Times (section/date) _____

() Internet _____

() Doctor _____

() Friend (name) _____

() Flyer (from) _____

() Website: www.jasinfacial.com

() other: _____

() Attended a Seminar

Where: _____

When: _____

For your convenience, we accept all major credit cards, Care Credit, and certified checks. We do not accept personal checks.

Patients Signature: _____ Date: _____

Cosmetic Health History

Name: _____ **Date:** _____

Age: _____ **Weight:** _____ **Date of Last Physical:** _____

Name of Your Primary Care Physician: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Office Phone # _____ **Fax #** _____

Chief Complaint and Areas of Concern:

Type of Procedure Considering:

Past Medical History: Do You Have a History of Any of the Following:

_____ Heart Disease	_____ Hypertension	_____ Diabetes
_____ Asthma	_____ Seizures	_____ Hepatitis
_____ Hypo/Hyper Thyroid	_____ Heart Murmur	_____ Rheumatic Fever
_____ HIV/AIDS	_____ Malignant Hyperthermia	_____ Cancer
_____ Myasthenia Gravis	_____ Cold Sore/Fever Blisters	_____ Other, Specify

List any Previous Surgery or Hospitalizations with Approximate Dates:

Current Medications: Please List All Medications you are Taking Prescribed or over-the-counter and the condition for which you take the medications :

Do you have any Drug Allergies: (circle) Yes No

Allergies: Please List any Allergies or reactions to Any Medication, Drugs, Soaps, Solutions, Food, or Latex, and the reaction you experienced :

If you are currently experiencing any pain, describe below the location and current treatment, and rate your pain on 1-10 scale (10= most severe)

Signature of Patient: _____ **Date:** _____

Cosmetic Health History

Social History:

Do You Smoke: (circle) Yes No

If Yes How Much?_____.

If You Smoked Previously When Did You Quit?_____.

Do You Drink Alcohol: (circle) Yes No

Daily_____ Weekly_____ Weekends_____ Occasionally_____

Review of Systems:

Please indicate if you are Experiencing any of the following symptoms.

_____Hearing Difficulty	_____Blurred Vision	_____Nosebleeds
_____Dysphagia (difficulty swallowing)	_____Coughing Blood	_____Chronic Cough
_____Shortness of Breath	_____Chest Pain	_____Nausea
_____Vomiting	_____Blood in Stool/Urine	_____Swelling
_____Joint Pain/Stiffness	_____Painful Urination	_____Syncope (fainting)

Have you ever been on Accutane? (Circle) Yes No

If Yes When ?_____

Women Only

Are you Pregnant: Yes No Are you Taking Birth Control Pills: Yes No

Are you Nursing: Yes No Do You Have Menstrual Problems: Yes No

Do you Wish to have a Pregnancy Test: Yes No

If Yes to any of the Above, Please Explain._____

Signature of Patient_____ **Date**_____

Physician Reviewed_____ **Date**_____

Time _____

Patients Name: _____ **Date:** _____

Thank you for visiting The Jasin Facial Rejuvenation Institute. We offer a wide variety of services to help you achieve your goal of facial/body rejuvenation. To help us better serve you, please take a few moments to complete this questionnaire to let us know your primary areas of concern and any procedures you may be interested in now or in the future. Thank you for your assistance.

PLEASE CHECK WHICH OF THE FOLLOWING AREA'S CONCERN TO YOU:

- | | | |
|---|--|--|
| <input type="checkbox"/> Acne scars | <input type="checkbox"/> Double chin | <input type="checkbox"/> Protruding ears |
| <input type="checkbox"/> Active acne | <input type="checkbox"/> Droopy brows | <input type="checkbox"/> Puffy eyelids |
| <input type="checkbox"/> Brown spots | <input type="checkbox"/> Flat cheek bones | <input type="checkbox"/> Sagging neck |
| <input type="checkbox"/> Desire change in shape of nose | <input type="checkbox"/> Jowls | <input type="checkbox"/> Spider veins |
| <input type="checkbox"/> Desire fuller lips | <input type="checkbox"/> Lines & wrinkles | <input type="checkbox"/> Weak chin |
| | <input type="checkbox"/> Moles/ Skin Lesions | <input type="checkbox"/> Other: _____ |

SERVICES:

The following is a list of services we provide at the Institute. Please indicate which cosmetic procedures may be of interest to you.

- | | |
|---|---|
| <input type="checkbox"/> Botox Treatments | <input type="checkbox"/> Laser resurfacing of skin lesions |
| <input type="checkbox"/> Browlift | <input type="checkbox"/> Laser resurfacing: Face, Eyes, Mouth |
| <input type="checkbox"/> Cheek implants | <input type="checkbox"/> Lip augmentation |
| <input type="checkbox"/> Chin implant | <input type="checkbox"/> Liposuction |
| <input type="checkbox"/> Facelift | <input type="checkbox"/> Non-Surgical Rhinoplasty |
| <input type="checkbox"/> Fat Transfer | <input type="checkbox"/> Otoplasty |
| <input type="checkbox"/> Hair Restoration | |
| <input type="checkbox"/> Injectable fillers (Juvederm, Restylane, Radiesse) | <input type="checkbox"/> Services Of Aesthetician |
| <input type="checkbox"/> Laser Blepharoplasty (<i>eyelid surgery</i>) | <input type="checkbox"/> Skin care products |
| <input type="checkbox"/> Simplicity Facelift | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Simplicity Neck Lift | <input type="checkbox"/> Peels |

I am thinking of having a procedure done in:

ASAP _____ 1-3 months _____ 3-6 months _____ 6-12 months _____