**Dr. Theodore Diktaban, M.D., F.A.C.S.**

 **635 Madison Avenue New York, NY 10022**

 **(212) 988-5656**

PATIENT REGISTRATION

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apt#\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, State\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Zip\_\_\_\_\_\_\_\_\_\_\_

Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ext \_\_\_\_\_ E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Internet/Website ⃝ Word-of-Mouth ⃝ Marketing/Email

Primary Care Physician (Name and Address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy (Name and Phone #) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status:

□ Married □ Widowed □ Single □ Divorced □ Partnered

**IN CASE OF EMERGENCY, CONTACT:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ext \_\_\_\_\_\_

**Medical History:**

Sex □ Male □ Female Age: \_\_\_\_\_\_\_\_\_ WT\_\_\_\_\_\_\_\_ HT\_\_\_\_\_\_\_\_\_\_ any blood transfusions\_\_\_\_\_\_\_\_\_\_\_\_

1. Reason for visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How long has this been going on? \_\_\_\_\_\_\_\_\_\_

2. Please list any Surgeries/Operations (Medical and Cosmetic) you have had in the past:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Complications? \_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Complications? \_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Complications? \_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | YES | NO |  | YES | NO |  | YES | NO |  |
| Anemia |  |  | Eye Disorders |  |  | HIV infections/AIDS |  |  |  |
| Asthma |  |  | Sensitivity/allergies |  |  | Kidney/bladder disease |  |  |  |
| Cancer |  |  | Heart Disease |  |  | Liver Disease |  |  |  |
| Cardiac Pacemaker |  |  | Keloids/Excessive Scar |  |  | Bleeding Disorder |  |  |  |
| Cold Sores |  |  | Hepatitis |  |  | Murmur |  |  |  |
| Depression |  |  | High Blood Pressure |  |  | Seizures/Stroke |  |  |  |
| Diabetes |  |  | Skin Cancer  |  |  | Thyroid Dissease |  |  |  |

Are you **ALLERGIC** to any medications (Please list them) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medical problems/conditions you may have and are currently being treated for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever needed or had a **blood transfusion**? YES WHY WHEN or NO

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need **antibiotics** before a surgical or dental procedures? YES NO

Are you currently on **blood thinners**? YES NO

Please **list all medications** you are currently taking .

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please check off anyone that applies **( Women ONLY**)

Pregnant or think you may be pregnant YES NO

Are you currently nursing( breastfeeding YES NO

Taking Oral Contraceptives YES NO

Taking Hormone replacement YES NO

Any Family or personal HX of Breast Cancer YES NO

Aspirin Consumption Never Occ Freq Daily

Ibuprofen, Aleve, Motrin/Advil Never Occ Freq Daily

Alcohol Consumption Never Occ Freq Daily

Cigarettes/ Vapor/ Cigars Never Occ Freq Daily

Recreational Drugs Never Occ Freq Daily

Caffeine Consumption Never Occ Freq Daily

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date Physician Initials Date