



Patient Registration Form

Clients are requested to complete this form as fully as possible as the more information you provide will allow us to make a more informed decision regarding your eligibility to complete a plastic surgery procedure. Please also refer to the section on photographs at www.plastic-surgery-phuket.com/Photographs

Please send the completed form to info@plastic-surgery-phuket.com

PATIENT DETAILS

Title Name :	<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	*
First Name :	<input type="text"/>				*
Middle Name :	<input type="text"/>				
Family /Last Name :	<input type="text"/>				*
Gender :	<input type="checkbox"/> Male	<input type="checkbox"/> Female			*
Date Of Birth :	<input type="text"/> / <input type="text"/> / <input type="text"/>				*
Height :	<input type="text"/>	Cm.			
Weight :	<input type="text"/>	Kg.			
Blood Group :	<input type="text"/>				
Marital Status :	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	
Nationality :	<input type="text"/>				*

CONTACT INFORMATION

Home address :	<input type="text"/>	*
Address :	<input type="text"/>	*
Street:	<input type="text"/>	
City/Town :	<input type="text"/>	*
Country :	<input type="text"/>	*
Zip/Post Code :	<input type="text"/>	

Email : @ *

Tel(Home) :

Tel (Office) :

Mobile : *

How Long have you been living at your home address :
 Less than 1 year
 1-5 years
 More than 5 years

TRAVEL COMPANIONS DETAILS

Title Name : Mr Mrs Miss Ms

First Name :

Middle Name :

Family/Last Name :

BOOKING DETAILS

Procedure/s Requested :

Requested Date Of Surgery : / /

Depart Phuket on(Date) : / /

FAMILY MEDICAL CONDITION

	Not Known	None	Yes	(Please specify)
Heart Disease:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Diabetes :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Hypertension :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Asthma :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Cancer :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

PATIENTS MEDICAL CONDITION

	Not Known	None	Yes	(Please specify)
Heart Disease :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Diabetes :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Hypertension :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Deep Vein Thrombosis :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Cardiovascular Accidents :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Asthma :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Bleeding Tendency :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Hyperthyroidism :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Hypothyroidism :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Adrenal Insufficiency :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Hepatitis :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
HIV :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Keloid Scarring :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Cancer :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Major Operation :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Underlying Disease :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Drug Allergies :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Food Allergies :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Current Medications and Dosage :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Current vitamins, food/nutritional supplements :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Have you ever been treated for depression :

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
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HABITS HISTORY

	Not Known	None	Yes	(Please specify)
Smoking :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Drinking :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

FOR WOMEN ONLY

	Not Known	None	Yes	(Please specify)
Birth control pills , hormone replacement medications , hormone patch / implant :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Are you pregnant now :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Planning for more pregnancies? :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Age of youngest child :

Last breastfed on (month & year) :

 /

BREAST SURGERY DETAILS

Current Bra Size:

Requested Size :

Desired Placement :

Desired Implant :

Desired Incision :