MARK VINCENT SOFONIO, M.D., F.A.C.S.

BOARD CERTIFIED PLASTIC AND RECONSTRUCTIVE SURGEON
Eisenhower Medical Center * 39000 Bob Hope Drive, Kiewit Building, Suite 407* Rancho Mirage, CA 92270
760-341-5555 Office | 760-341-8054 Fax

PATIENT REGISTRATION

Date:___/___/____ May we contact you to confirm appointments, etc?: Yes No

NAME:_____ **DATE OF BIRTH**: ___/____/_____
LAST FIRST

YOUR AGE: _____ **FEMALE:** **MALE:** SPOUSE OR SIGNIFICANT OTHER NAME: _____

MARITAL STATUS: Single Married Widowed Divorced ANNIVERSARY (IF MARRIED)_____/_____/_____

PRIMARY ADDRESS:_____ CITY:_____ STATE:_____ZIP:_____

SECONDARY ADDRESS:_____ CITY:_____ STATE:_____ZIP:_____

HOME PHONE:(_____)_____-_____ CELL PHONE:(_____)_____-_____ WORK PHONE:(_____)____-_____

OCCUPATION:_____EMPLOYER:_____

SOCIAL SECURITY #:_____-_____-_____ DRIVERS LICENSE #: _____ STATE: _____

EMAIL: _____@_____ **May we send you information regarding specials, etc. Yes No**

How did you hear about us?_____ Have you ever had a cosmetic procedure before? Yes No

Please describe The Reason For Today's Consultation?_____

MEDICATION ALLERGIES: _____

Other Allergies (check all that apply): Latex Aspirin Ibuprofen Animals Pollen/Hay Fever Fragrance/Perfume
"cillin" Medications "caine" Medications (example: lidocaine, benzocaine) Metals Foods (please specify):_____

Cosmetic Ingredient Sensitivity or Allergies (check all that apply): Aloe Vera Sulphur Benzoyl Peroxide Hydroquinone
Progesterone Glycolic Cortisone Vitamin C Topical Vitamin E Topical Sunscreen Retin A/Retinol

Do You Have Any Metal Implants? No Yes: (Location?) _____

Do You Have an Implanted Cardioverter/Defibrillator, Pacemaker or Heart Valve? No Yes

Have You ever Had Bad Experience in the Dental Office? No Yes (Why?):_____

Are You Currently Seeing a Dermatologist? No Yes (Why?):_____

List Major Illness, Surgeries, or Chronic Problems (Past 5 Years):_____

Have You Ever Had a Cosmetic Surgery? (Type & When?): _____

Check All Fillers Used: Silicone Artefil Sculptra Radiesse Juvederm/Restylane Collagen Other_____

Check Any of the Following Medical Conditions That Apply:

Thyroid Condition Hormone Imbalance Asthma Lupus Rosacea Immune Disorder
High Blood Pressure Epilepsy/Seizures HIV Hepatitis A Hepatitis B Hepatitis C
Systemic Disease Migraine Headaches Diabetes Liver Disease Heart Disease Genital Herpes
Cancer Multiple Sclerosis Bruise Easily History of Stroke Kidney Trouble
Cold Sores (Frequency/year:_____) Myasthenia Gravis Parkinson's Disease
Lambert-Eaton Lou Gherig's Disease Other: _____

List ALL Prescriptions & Over the Counter Medications You Are Currently Taking
(Including Aspirin, Ibuprofen, Herbs & Vitamins)

1._____ 2. _____ 3_____ 4_____ 5_____

6. _____ 7. _____ 8_____ 9_____ 10_____

List ALL SURGICAL PROCEDURES THAT WERE NON-COSMETIC:

1. _____-DATE_____ 2. _____-DATE_____

3. _____-DATE_____ 4. _____-DATE_____

Indicate the type(s) of ANESTHESIA received in the past, list any complications/reactions you experienced:

Local anesthesia -complications/reactions: _____
General anesthesia- complications/reactions: _____
Spinal/Epidural - complications/reactions: _____

Have you ever received a transfusion? No Yes If yes, what year? _____

Have you been tested for HIV? No Yes If yes, what year? _____ Test Results? Positive Negative

Primary Care Physician (Name):_____ Phone: (_____)_____-_____

Address:_____ City:_____ State: _____ ZIP: _____

Date Last Seen By Primary Care Physician: _____ Reason: _____

INSURANCE INFORMATION:

Medical Insurance: Company: _____ Policy #:_____Group #:_____

Insured's Name: _____ Group Name: _____

General Health Questions:

Tobacco Use: Yes No Pain Threshold: Low Medium High Regular Sleep Patterns: : No Yes
Alcohol: Yes No Amount in a week?_____drinks Plain Water: (# of 8oz. glasses per day) 1-2 3-4 6-8+
Exercise (days per week): None 1-2 3-4 5 + Claustrophobia: Yes No Contact Lense: Yes No
Caffeine (soda, coffee, tea per day): None 1-2 3+ Restricted Diet: Yes No

For Women Only – Check Any That Currently Apply:

Are You Pregnant? No Yes Do you anticipate becoming pregnant? Yes No Menopausal
Using Hormone Replacement Therapy acne flare-ups that seem related to menstrual cycle Nursing until: __/__/__
Biirth Control (which method?) _____

This practice is governed by the California Medical Board.
Be advised that Dr. Mark Sofonio is the sole owner/individual with a financial interest in this practice.

_____ _____
Patient Signature Date