



John L. Porcaro, MD, FACS, FAACS  
 1943 SE Port St. Lucie Blvd.  
 Port St. Lucie, FL 34952  
 www.porcarosurgical.com

## Patient Registration

(Please Print Clearly)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Work phone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

E-mail address: \_\_\_\_\_ Referred by: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Married  Widowed  Single  Separated  Divorced  Partnered for \_\_\_\_\_ yrs

Spouse/Significant Other's Name: \_\_\_\_\_

Emergency contact person: \_\_\_\_\_ Phone number: (\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_

What is your main reason for visiting our office today? \_\_\_\_\_

Please note any of the following that you may be interested in:

- Lipotherme Laser  Liposculpture  Fat Transfer  Tummy Tuck  Hair Transplant  Hormone Replacement
- Laser Hair Restoration  Eyelid Surgery  Face Lift  Botox  Restylane  Juvederm
- Sculptra  Sclerotherapy for varicose & spider vein  Breast Augmentation  Breast Lift  Breast Reduction
- Male Breast Reduction  Labiaplasty  Vaginoplasty  Laser Acne Treatments  Laser Facial Rejuvenation
- Skincare Products  Skincare Consultation  Facial Peels  Microdermabrasion  Permanent make-up

May we contact you to remind you of upcoming appointments or to reschedule/schedule missed or future appointments?  YES  NO

May we contact you regarding new services, products or procedures we think you might be interested in?  YES  NO

Would you be interested in hearing about any seminars or other events our office will be hosting?  YES  NO

Do you prefer being contacted by phone or e-mail?  Phone  E-mail

If by phone, when is the best time to call you? \_\_\_\_\_ Which number do you prefer we use?  Home  Cell  Work

Do we have your permission to leave a message on your voice mail, answering machine, or with the person who answers the phone?  YES  NO

Would you be interested in receiving special offers by e-mail from our office?  YES  NO

- I acknowledge that for security purposes Porcaro Hair & Cosmetic Surgery may preserve any and all medical records and related documents by electronic scan and/or computerized means and that the original physical documents may be destroyed.
- I agree that any and all electronic formats (i.e. scanned) shall have the same legal and medical effects as destroyed originals.

Patient Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_

Please answer ALL the questions and fill in the blanks when indicated.

1. Are you in good health?			<input type="checkbox"/> Y <input type="checkbox"/> N
2. Your last physical examination was:			
3. Are you under the care of a physician?			<input type="checkbox"/> Y <input type="checkbox"/> N
If so, what is the condition being treated?			
4.a What's your height:	4.b What's your weight now:	4.c What's the most you ever weighed (including pregnancy):	
5. Have you had any serious illness or operation?			<input type="checkbox"/> Y <input type="checkbox"/> N
6. Have you been hospitalized or had a serious illness within the past five (5) years?			<input type="checkbox"/> Y <input type="checkbox"/> N
7. Do you drink alcoholic beverages      NEVER      SOCIALLY      SOMETIMES      REGULARLY			
8. Do YOU have, or have YOU had, any of the following diseases or problems?			
Rheumatic fever or rheumatic heart disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Low blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N
Kidney trouble; kidney failure	<input type="checkbox"/> Y <input type="checkbox"/> N	Venereal disease, genital herpes, STD, HIV, AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N
Cardiovascular disease - heart trouble, heart attack	<input type="checkbox"/> Y <input type="checkbox"/> N	High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N
Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke, TIA	<input type="checkbox"/> Y <input type="checkbox"/> N
Cardiac stents	<input type="checkbox"/> Y <input type="checkbox"/> N	Prosthetic joints or metal plates	<input type="checkbox"/> Y <input type="checkbox"/> N
Pain in your chest upon exertion, Palpitations	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Recent upper respiratory tract infection	<input type="checkbox"/> Y <input type="checkbox"/> N	Cancer, now or in the past	<input type="checkbox"/> Y <input type="checkbox"/> N
Are you short of breath after mild exercise	<input type="checkbox"/> Y <input type="checkbox"/> N	Cold Sores/fever blisters/shingles/herpes	<input type="checkbox"/> Y <input type="checkbox"/> N
Difficult Airway	<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma, Cataracts, Dry eyes	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you get short of breath when you lie down or do you require extra pillows for sleep	<input type="checkbox"/> Y <input type="checkbox"/> N	High cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma, COPD, emphysema, bronchitis, cough	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid disorder	<input type="checkbox"/> Y <input type="checkbox"/> N
Sleep Apnea	<input type="checkbox"/> Y <input type="checkbox"/> N	Smoker	<input type="checkbox"/> Y <input type="checkbox"/> N
Hives, skin rash, eczema, hay fever, acne	<input type="checkbox"/> Y <input type="checkbox"/> N	Presently using nicotine patches	<input type="checkbox"/> Y <input type="checkbox"/> N
Fainting spells, seizures, epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Chemical dependency	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Collagen/Vascular disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Urinate more than 6 (six) times per day	<input type="checkbox"/> Y <input type="checkbox"/> N	Psychiatric problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Thirsty much of the day	<input type="checkbox"/> Y <input type="checkbox"/> N	Recent weight loss/eating disorder	<input type="checkbox"/> Y <input type="checkbox"/> N
Dry eyes, prior eye surgery, contact lenses	<input type="checkbox"/> Y <input type="checkbox"/> N	Heal poorly/form keloids	<input type="checkbox"/> Y <input type="checkbox"/> N
Lupus	<input type="checkbox"/> Y <input type="checkbox"/> N	Curvature of the spine; scoliosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N	Prior complications with anesthesia during surgery	<input type="checkbox"/> Y <input type="checkbox"/> N
Inflammatory rheumatism (painful swollen joints)	<input type="checkbox"/> Y <input type="checkbox"/> N	Refused as a blood donor	<input type="checkbox"/> Y <input type="checkbox"/> N
Stomach ulcers, hiatal, hernia, reflux, aspiration risk	<input type="checkbox"/> Y <input type="checkbox"/> N	History of blood clots or pulmonary embolus	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you have any blood disorders such as anemia or hemophilia?	<input type="checkbox"/> Y <input type="checkbox"/> N	Edema/Lymphedema	<input type="checkbox"/> Y <input type="checkbox"/> N
Bruise easily	<input type="checkbox"/> Y <input type="checkbox"/> N	Abnormal bleeding associated with previous tooth extractions, surgery or trauma	<input type="checkbox"/> Y <input type="checkbox"/> N
Required a blood transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N	Infection; hemorrhage	<input type="checkbox"/> Y <input type="checkbox"/> N
Hepatitis A, B or C; Cirrhosis; Liver disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Recent weight loss or gain	<input type="checkbox"/> Y <input type="checkbox"/> N
Immune disorder; Compromised Immune System	<input type="checkbox"/> Y <input type="checkbox"/> N	Removed spleen	<input type="checkbox"/> Y <input type="checkbox"/> N
Inflammatory Bowel Disease; Crohn's	<input type="checkbox"/> Y <input type="checkbox"/> N	Varicose Veins, swollen legs; swollen ankles	<input type="checkbox"/> Y <input type="checkbox"/> N
Anxiety, phobias	<input type="checkbox"/> Y <input type="checkbox"/> N	Depression	<input type="checkbox"/> Y <input type="checkbox"/> N
Are you:		Do you have, or have you ever had problems with:	
Happy?	<input type="checkbox"/> Y <input type="checkbox"/> N	Nervousness, tension, feeling down or blue	<input type="checkbox"/> Y <input type="checkbox"/> N
Stressed?	<input type="checkbox"/> Y <input type="checkbox"/> N	History of a nervous breakdown	<input type="checkbox"/> Y <input type="checkbox"/> N
Excited?	<input type="checkbox"/> Y <input type="checkbox"/> N	History of counseling or psychiatric treatment	<input type="checkbox"/> Y <input type="checkbox"/> N
Distressed?	<input type="checkbox"/> Y <input type="checkbox"/> N	Weight been stable for the last 6 months	<input type="checkbox"/> Y <input type="checkbox"/> N
Pleasant?	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you plan to loose weight in the near future?	<input type="checkbox"/> Y <input type="checkbox"/> N
Anxious?	<input type="checkbox"/> Y <input type="checkbox"/> N		
Depressed?	<input type="checkbox"/> Y <input type="checkbox"/> N		

Please explain all "Yes" responses and diseases, conditions or problems not listed: \_\_\_\_\_

**9. Are YOU taking any of the following?**

- Antibiotics or sulfa drugs  Y  N
- Anticoagulants (blood thinners)  Y  N
- Medicine for high blood pressure  Y  N
- Tranquilizers  Y  N
- Narcotics  Y  N
- Cortisone (steroids) within last 6 mos.  Y  N
- Aspirin  Y  N
- Insulin, tolbutamide (Orinase) or similar drugs  Y  N
- Nitroglycerin  Y  N
- Drugs for heart trouble  Y  N
- Chemotherapy  Y  N
- Home Oxygen or CPAP  Y  N
- Accutane within past 6 mos.  Y  N
- Birth Control Pills  Y  N
- Hormone Replacement  Y  N
- Recreational drugs (Marijuana; cocaine)  Y  N
- Reflux Medications  Y  N
- Other: \_\_\_\_\_  Y  N

**10. Are YOU allergic or have you reacted adversely in any way to the following?**

- Local anesthetics  Y  N
- Penicillin or other antibiotics  Y  N
- Sulfa drugs  Y  N
- Aspirin  Y  N
- Iodine  Y  N
- Latex  Y  N
- Barbiturates, sedatives or sleeping pills  Y  N
- Narcotics  Y  N
- General anesthesia  Y  N
- Other \_\_\_\_\_  Y  N

Do you have any disease, condition or problem NOT listed? If yes, please explain: \_\_\_\_\_

Please list ALL drugs, medications including eyedrops, prescription and over the counter, vitamins, minerals, supplements, including herbal supplements YOU are taking including frequency and dosage:

**11. FAMILY HISTORY:** Have any of YOUR BLOOD RELATIVES ever had the following problems:

Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Surgery	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Abnormal Clotting	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Anesthetic Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N	Other Serious Illness	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N	Breast Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N
Deep Vein Thrombosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Pulmonary Emolus	<input type="checkbox"/> Y <input type="checkbox"/> N		

Please describe all "Yes" answers: \_\_\_\_\_

Pregnant or could be pregnant	<input type="checkbox"/> Y <input type="checkbox"/> N	Hysterectomy	<input type="checkbox"/> Y <input type="checkbox"/> N
Taking birth control pills	<input type="checkbox"/> Y <input type="checkbox"/> N	Taking hormone replacement at this time	<input type="checkbox"/> Y <input type="checkbox"/> N
Number of pregnancies	<input type="checkbox"/> Y <input type="checkbox"/> N	Polycystic ovaries	<input type="checkbox"/> Y <input type="checkbox"/> N
Ovarian, adrenal, pituitary problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Mammogram within 1 yr	<input type="checkbox"/> Y <input type="checkbox"/> N
Hereditary problems of breast cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Breast biopsies	<input type="checkbox"/> Y <input type="checkbox"/> N
Satisfied sex life	<input type="checkbox"/> Y <input type="checkbox"/> N	Tubal ligation	<input type="checkbox"/> Y <input type="checkbox"/> N
Pap smear within 1 year	<input type="checkbox"/> Y <input type="checkbox"/> N	Sexually active	<input type="checkbox"/> Y <input type="checkbox"/> N
Number of children	<input type="checkbox"/> Y <input type="checkbox"/> N	Cesarean Section	<input type="checkbox"/> Y <input type="checkbox"/> N
Last menstrual period	<input type="checkbox"/> Y <input type="checkbox"/> N	Have periods stopped?	<input type="checkbox"/> Y <input type="checkbox"/> N
Sleep disruption/Insomnia	<input type="checkbox"/> Y <input type="checkbox"/> N	Fatigue	<input type="checkbox"/> Y <input type="checkbox"/> N
Short term memory loss/Foggy Thinking	<input type="checkbox"/> Y <input type="checkbox"/> N	Weight gain	<input type="checkbox"/> Y <input type="checkbox"/> N

**FOR WOMEN (cont.)**

Hot flashes/Menopausal symptoms	<input type="checkbox"/> Y <input type="checkbox"/> N	Decreased sex drive	<input type="checkbox"/> Y <input type="checkbox"/> N
Vaginal dryness	<input type="checkbox"/> Y <input type="checkbox"/> N	Depression	<input type="checkbox"/> Y <input type="checkbox"/> N
Irritability	<input type="checkbox"/> Y <input type="checkbox"/> N	Bladder symptoms	<input type="checkbox"/> Y <input type="checkbox"/> N
Nervousness	<input type="checkbox"/> Y <input type="checkbox"/> N	Night sweats	<input type="checkbox"/> Y <input type="checkbox"/> N
Harder to reach climax	<input type="checkbox"/> Y <input type="checkbox"/> N	Breast tenderness	<input type="checkbox"/> Y <input type="checkbox"/> N
Wrinkling and thinning of the skin	<input type="checkbox"/> Y <input type="checkbox"/> N	Hair loss	<input type="checkbox"/> Y <input type="checkbox"/> N
PMS symptoms	<input type="checkbox"/> Y <input type="checkbox"/> N	Menstrual migraines	<input type="checkbox"/> Y <input type="checkbox"/> N
Osteoporosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Chronic fatigue syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N
Fibromyalgia	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have any bleeding between periods?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you have any cramping with your periods?	<input type="checkbox"/> Y <input type="checkbox"/> N	How many days does your period last?	
Are/were YOUR periods regular?	<input type="checkbox"/> Y <input type="checkbox"/> N	Could you have a hormone deficiency?	<input type="checkbox"/> Y <input type="checkbox"/> N

**13. FOR MEN:**

Fatigue	<input type="checkbox"/> Y <input type="checkbox"/> N	Short term memory loss/ Foggy Thinking	<input type="checkbox"/> Y <input type="checkbox"/> N
Decreased energy level	<input type="checkbox"/> Y <input type="checkbox"/> N	Decreased sex drive	<input type="checkbox"/> Y <input type="checkbox"/> N
Anxiety	<input type="checkbox"/> Y <input type="checkbox"/> N	Irritability	<input type="checkbox"/> Y <input type="checkbox"/> N
Depression	<input type="checkbox"/> Y <input type="checkbox"/> N	Loss of muscle mass	<input type="checkbox"/> Y <input type="checkbox"/> N
Mood swings	<input type="checkbox"/> Y <input type="checkbox"/> N	Sleep disorder	<input type="checkbox"/> Y <input type="checkbox"/> N
Prostate cancer/ Prostate Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Erectile dysfunction/Easy to loose erection	<input type="checkbox"/> Y <input type="checkbox"/> N
Premature ejaculation	<input type="checkbox"/> Y <input type="checkbox"/> N	Satisfying sex life	<input type="checkbox"/> Y <input type="checkbox"/> N
PSA in last year	<input type="checkbox"/> Y <input type="checkbox"/> N	Used Steroids; hair loss	<input type="checkbox"/> Y <input type="checkbox"/> N
Sleep Disruption/ Insomnia	<input type="checkbox"/> Y <input type="checkbox"/> N	Could you have a Hormone Deficiency?	<input type="checkbox"/> Y <input type="checkbox"/> N
Number of children fathered	_____	Taking Hormones at this time?	<input type="checkbox"/> Y <input type="checkbox"/> N

Comments: \_\_\_\_\_

14. List ALL your Non-cosmetic surgeries (i.e. Hernia Repair, Appendectomy, Gallbladder, Hysterectomy, Cesarean Section, Tubal Sterilization, Lasix, Cataract Surgery) and dates: \_\_\_\_\_

15. List ALL your Cosmetic surgeries (i.e. Face lift, Eyelid lift, Breast augmentation, Tummy tuck, Liposuction) and Dates: \_\_\_\_\_

16. List ALL your Botox, Restylane, Juvederm, Sculptra, Silicone Injections, etc. and dates: \_\_\_\_\_

17. I acknowledge that it is my responsibility to accurately inform Dr. John L. Porcaro of any medications, medical history or information possibly relevant to my treatment and/or surgery. Any misinformation, purposeful or otherwise may lead to improper treatment and potentially adverse reactions to proposed medications. Any purposeful misinformation related to the information presented in this record may result in termination of the doctor patient relationship and any care with Porcaro Hair & Cosmetic Surgery. By signing below, I acknowledge that the information I provided regarding my medical history is correct and I will keep this information up to date by informing the office of any change in my medications or in my health.

18. I acknowledge that I have reviewed a copy of "Porcaro Financial Policy" and by signing below I understand and agree to comply with the Financial Policy dated 09-11.

19. I acknowledge that I have had the chance to review a copy of "Porcaro Notice of Privacy Practices"

<b>Patient Signature: X</b>	Date
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Doctor's Notes:

Dr. Porcaro's Signature	Date
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**Driving Directions to Porcaro Hair and Cosmetic Surgery  
1943 S.E. Port St. Lucie Blvd., Port St. Lucie, FL 34952**

**If you are North of our office: Traveling on I-95**

Take Exit 118 for Tradition Pkwy/Gatlin Blvd.

Follow the signs to Port St. Lucie Blvd

Turn Left and go East heading toward U.S.1

Continue on Port St. Lucie Blvd. heading East until you pass through both the Morningside and Gowin lights make an immediate left after you pass through the Gowin light (this will bring you to the side of our plaza which is a large green building with white columns)

**If you are South of our office Traveling on I-95**

Take Exit 101 Kanner Highway

Follow the signs to U.S.1

Take U.S.1 North to Port St. Lucie

Turn Left on Port St. Lucie Blvd.

We are a block in on the North side of the Blvd. (large green building with white columns)

**From Florida Turnpike**

Exit 142 Port St. Lucie

Take exit 142 toward Port St. Lucie Toll Road

Merge onto SW Bayshore Blvd. (signs for Bayshore N)

Turn right at SW Port St. Lucie Blvd.

Continue on Port St. Lucie Blvd. heading East until you pass through both the Morningside and Gowin Lights make your immediate left after you pass through the Gowin light (this will bring you to the side of our plaza which is a large green building with white columns)

**From U.S.1**

If you are traveling North on U.S.1 turn left onto Port St. Lucie Blvd.

We are a block in on the North side of the Blvd. (large green building with white columns)

If you are traveling South on U.S.1 turn right onto Port S. Lucie Blvd.

We are a block in on the North side of the Blvd. (large green building with white columns)