BEFORE YOUR CONSULTATION

Patient registration *and medical history*

FILE NO. _____

Please fill this in before your consultation. Dr. ElKhoury reads it before you meet, and it is kept in your medical record. Answer as fully as you can. If you are unsure about a medication, bring the box.

HOW TO FILL THIS IN Use a pen. Tick one box on each line. If you are not sure of an answer, leave it blank and ask at the clinic.

01 Your details

Full name _____ **Date of birth (DD / MM / YYYY)** _____

Sex
☐ Female ☐ Male

Occupation _____

Phone / WhatsApp _____ **Email** _____

Address _____

Emergency contact _____ **Relationship** _____ **Their phone** _____

02 Your visit

What you would like to discuss

☐ Eyelid surgery ☐ Nose surgery ☐ Liposuction ☐ Tummy tuck ☐ Male chest ☐ Botulinum toxin
☐ Dermal filler ☐ Keloid scar

In your own words, what would you like to change?

_____

_____

How you found the practice

☐ Instagram ☐ Google ☐ Website ☐ Friend or family ☐ Another doctor ☐ Other

FOR THE CLINIC — Review

Reviewed by _____ **Date** _____ **BMI** _____

Red flags

☐ Blood thinners ☐ Smoker ☐ Diabetes ☐ Clot history ☐ Allergy ☐ Anaesthesia problem
☐ Pregnant or breastfeeding

Notes _____

Identity checked, signature confirmed in person (initials) _____ **Date** _____

PATIENT REGISTRATION · CONTINUED

03 Medical history

Tick Yes or No for each. Add a detail where you answer Yes.

Height (cm) _____ **Weight (kg)** _____ **Your regular doctor** _____

	YES	NO	DETAILS
High blood pressure	☐	☐	
Heart disease or palpitations	☐	☐	
Diabetes	☐	☐	
Asthma or lung disease	☐	☐	
Bleeding problems or easy bruising	☐	☐	
A blood clot in a leg or lung, ever	☐	☐	
Thyroid disease	☐	☐	
Kidney or liver disease	☐	☐	
Epilepsy or seizures	☐	☐	
Anxiety, depression or another mental health condition	☐	☐	
Autoimmune disease	☐	☐	
Keloid or thick scars	☐	☐	
Hepatitis or HIV	☐	☐	
Pregnant or breastfeeding now	☐	☐	
A problem with anaesthesia, you or a relative	☐	☐	

PATIENT REGISTRATION · CONTINUED

04 Medications and habits

Medications you take, with the dose

	YES	NO	DETAILS
Aspirin, blood thinners, or supplements such as fish oil, vitamin E, ginkgo or herbal remedies	☐	☐	

Allergies (medications, latex, iodine, dressings or tape) and what happened

Cigarettes, vapes or narghile per day (0 if none)

Alcoholic drinks per week

05 Previous surgery and treatments

Operations you have had, with the year

Cosmetic treatments you have had (filler, toxin, threads, laser), with the year

06 Declaration

The information above is complete and accurate to the best of my knowledge. I will tell the clinic if anything changes before my treatment. It is kept in my medical record and used only for my care.

Patient signature

Date

×