

## Registration and Medical History

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**Elizabeth Morgan MD PhD FACS**

**2045 Peachtree Rd NE  
Suite 412, Atlanta, GA 30309  
404/941-3200**

**1505 Northside Blvd, #4700A  
Cumming, GA 30041  
678/679-4683**

Your contact information and medical history are important. If some information is too private to write down, mention it to Dr. Morgan. It does not go in your chart.

### REGISTRATION

While you fill out this form, please give our staff your driver's license to be copied and also your insurance card – if insurance is involved. Thank you.

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

Title, e.g. Mrs, Ms, Miss, Mr, Dr, Ambassador, etc: \_\_\_\_\_

How do you wish to be addressed by our staff? \_\_\_\_\_

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

Phone numbers: Work \_\_\_\_\_ Home \_\_\_\_\_ Cell \_\_\_\_\_

At which number(s) may we call you or leave a message?

Work Yes/No          Home Yes/No          Cell Yes/No

Email: \_\_\_\_\_

Would you like to receive emails on monthly specials & events? Y / N

Name/address/phone numbers for family member or friend to contact if needed:  
\_\_\_\_\_

Name, address, phone of your primary care and other current physicians if any:  
\_\_\_\_\_

Social Security Number, last 4 digits, if health insurance is involved \_\_\_\_\_

By whom were you referred: Name and phone/address if known  
\_\_\_\_\_

May we let them know you have seen us? \_\_\_\_\_

# Registration and Medical History

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Date: \_\_\_\_\_ Name \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Birthdate \_\_\_\_\_

## Reason for your visit

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**Do you wear glasses?** \_\_\_\_\_ **Contacts** \_\_\_\_\_ **Last eye exam** \_\_\_\_\_  
Circle reason for glasses: Reading Driving Astigmatism Other \_\_\_\_\_

**Allergies and Reactions:** List *any* bad effects from a food or drug, and what it did.  
Swelling, hives and skin rashes are especially important:

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**Smoker?** How many/day \_\_\_\_\_ **Past smoker?** When did you stop? \_\_\_\_\_

**Caffeine?** How much on an average day? \_\_\_\_\_ Or average week \_\_\_\_\_

**Alcohol?** How much on an average day \_\_\_\_\_ Or an average week \_\_\_\_\_

**Exercise:** How much on an average day \_\_\_\_\_ Or an average week \_\_\_\_\_

**Work:** How much in an average day \_\_\_\_\_ Or an average week \_\_\_\_\_

**Prednisone or other steroids:** When, what dose,  
reason: \_\_\_\_\_

Please list **all prescription medicines, doses and reason for taking the medicine:**

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Please list all non-**prescription medicines, herbals and supplements, doses and reason for taking them:**

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Do you take **recreational drugs:** \_\_\_\_\_



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**CIRCLE ANY THAT APPLY TO YOU – if you didn't include them on Page 2.**

Headaches	Seizure	Stroke	Depression/Insomnia
Anxiety	Deafness	Blindness	Glaucoma
Near vision	Dizziness	Nerve injury	Post-traumatic stress
Infections	Herpes	Hives	Ulcerative colitis
Crohn's	Raynaud's	Sjogren's	Dry eye
Extreme fatigue	Night sweats	Hashimoto's	Auto-immune disease
Cold sores	Psoriasis	Burns	Severe sunburn
Acne	Skin cancer	Dermatitis	Shortness of breath
Nose bleeds	Nose allergies	Strep throat	Chronic cough
Trouble swallowing	Asthma	Pneumonia	Emphysema
COPD	Bronchitis	Wheezing	Heart/chest pain
High cholesterol	Diabetes	High Thyroid	Low thyroid
High blood pressure	Varicose veins	Aching legs	Stomach ulcers
Jaundice	Hepatitis	Gallstones	Pancreatitis
Kidney stones	Bladder infections	Kidney infections	Kidney failure
Transfusions	Trouble sleeping	Bleeding/bruising	Hair thinning
Low platelets	Concussion	Bell's Palsy	Blood clots
Rheumatoid arthritis	Rheumatic fever	Bloating	Poor circulation
Heart attack	Heart murmur	Lyme Disease	Heart failure
Neck pain	Shoulder pain	Reflux	Back pain
Deviated septum	Sinus infections	Stroke	Snoring/sleep apnea
Heart attack	Aneurysm	Giardia	West Nile Virus
Temporal arteritis	Polymyalgia	Fibromyalgia	Fractures
Tumors, benign	Tumors, malignant	Ulcers	Ascites
Bloating	Swelling	Bleeding	Diarrhea
Trouble urinating	Trouble passing stool	Change in bowel/bladder function	
Sleep Apnea			

**Have you had stomach pain, diarrhea, jaundice, severe headache, personality change or extreme fatigue from any medicine – not described above – including:**

Reglan	Levaquin	Metronidazole (Flagyl)	Tindamax	Tylenol
Keflex	Cipro	Monistat	Hormones	Compazine
Other _____				

**For women:** Pregnancies \_\_\_\_\_ Children \_\_\_\_\_ Last menses \_\_\_\_\_ Menopause \_\_\_\_\_

Breast Surgery \_\_\_\_\_ Breast biopsy \_\_\_\_\_

Last mammogram \_\_\_\_\_ Was it normal? \_\_\_\_\_ If you have breast implants, do you have muscle and joint stiffness since surgery? \_\_\_\_\_

Is there any chance that you are pregnant or might be before surgery? \_\_\_\_\_

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Any other health issues or concerns?

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Do you have cosmetic concerns not related to plastic surgery, such as your teeth?  
We are happy to help you find the best specialist for problems in other specialties.  
Thank you.

Please sign and date:

Signature\_\_\_\_\_Date\_\_\_\_\_