Jacobson Cosmetic Surgery
Dr. Jessica Jacobson DO
1630 S 70th St Suite 202
Lincoln NE 68506
Phone: (531) 254-5458
Fax: (531) 254-5065

Date: ________________

PATIENT REGISTRATION

First Name: ___________________________ M.I.: ______ Last Name: ________________________________

DOB: ___/___/______ Preferred Name/Nickname: _______________ Preferred Language: _______________

Address: __________________________________ City: ________________ State: ________ Zip: __________

Occupation: ________________________________ Employer: _______________________________________

Primary Phone: ______________________________ Secondary Phone: _______________________________

Can we leave a voicemail on either of these phones?

☐ Yes ☐ No

Email: ____

Would you like to receive information on discounts, specials and promotions?

☐ Yes ☐ No

Consent to Communicate (check all that apply)

☐ Phone-Call ☐ Text ☐ Email

Emergency Contact Information

Name: ____________________________ Relationship: _______________ Phone: __________________

How did you hear about us? (Check all that apply)

- ☐ Friend: __________________________
- ☐ Google/online search
- ☐ Facebook
- ☐ Instagram
- ☐ TV
- ☐ Magazine
- ☐ Patient Referral: ________________
- ☐ Dr. Referral: ____________________
- ☐ Other: _________________________

Name of Preferred Pharmacy/ Location: ____

Reason for today's visit: ____

Have you seen other cosmetic/plastic surgeons for this? ____________________________________

MEDICAL HISTORY

FAMILY HISTORY

Do you have a blood relative who had anesthesia complications of any kind?

- ☐ Yes
- ☐ No

If yes, please describe: ____

Have any blood relatives had the following?

			Family Member
Bleeding disorders	No	Yes	
Blood clots	No	Yes	
Breast cancer	No	Yes	
Cancer (any type)	No	Yes	
Diabetes	No	Yes	
Heart disease	No	Yes	
Hypertension (high blood pressure)	No	Yes	
Kidney disease	No	Yes	
Lung disease	No	Yes	

SURGICAL HISTORY

Have you ever had surgery? Please list surgeries and year:

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

MEDICAL HISTORY

Height: ___________________________ Weight: ___________________

Date of Last Mammogram (if applicable): _____/_____/_____

Are you pregnant?
☐ Yes ☐ No ☐ N/A

1. Have you had any of the following: (check in the box)

Bleeding disorder	No	Yes
Blood clots (DVT, pulmonary embolism)	No	Yes
Problem scarring/hypertrophic/keloid scars	No	Yes
Problems with general anesthesia	No	Yes
Wound healing issues	No	Yes

2. Have you had or do you still have: (check in the box)

Asthma	No	Yes
Autoimmune disease	No	Yes
Diabetes	No	Yes
Epilepsy or seizures	No	Yes
Have you been advised or had psychiatric care	No	Yes
Heart disease	No	Yes
Hepatitis/liver disease	No	Yes
Hypertension (high blood pressure)	No	Yes
Lung disease	No	Yes
Stroke	No	Yes
Thyroid disease	No	Yes

SOCIAL HISTORY

1. Do you smoke and/or vape?
   - ☐ Never smoked
   - ☐ Current smoker (amt): _____________
   - ☐ Past smoker (amt): ____________ for _____years, quit _____ (days/weeks/months) ago

2. Do you drink?
   - ☐ Never/rarely
   - ☐ Yes: _________drinks per week

3. Do you have children?
   - ☐ No
   - ☐ Yes, how many? __________

MEDICATIONS

Are you taking any medications, vitamins, or herbal supplements? If yes, please list:

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

Occasional Aspirin/Ibuprofen?

☐ Yes ☐ No

ALLERGIES

Allergy or reaction to:

☐ Tape/Adhesive ☐ Latex ☐ Anesthetic Agent

Allergies to medications (& what reaction is):

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

Signature: ____ Date: _____/_____/______