



PATIENT INFORMATION

Name _____ Age _____ Sex _____ Date _____

Preferred Designation _____ SS# _____ Driver's Lic# _____

Birthdate _____ Single Married Widowed Divorced

Address _____

City _____ State _____ Zip _____

Home (_____) _____ Work (_____) _____ Cell Phone (_____) _____

Occupation: _____ Email: _____

Who is responsible party: _____ Employer: _____

Person to contact in case of emergency: _____ (_____) _____

Referred by: _____

I will be consulting with Dr. _____ today and the purpose of this consult is to discuss _____

I. MEDICAL QUESTIONNAIRE: (Please indicate with a "X " all that apply)

Have you every had any heart problems?

- High blood pressure Low blood pressure
 Heart attack Irregular heartbeat
 Heart murmur Shortness of breath
 Chest pain/tightness

Have you every had any gastrointestinal problems?

- Ulcers Gastritis
 Colitis Diverticulitis

Have you every had any lung problems?

- Bronchitis/Pneumonia Asthma
 Heart attack Tuberculosis

Have you every had any musculoskeletal/ neurological problems?

- Convulsions Epilepsy
 Headaches Arthritis
 Other

Have you every had any eye, ear, nose or throat problems?

- Dry eyes
 Blurred vision Glaucoma
 Nosebleeds Corrective lenses
 Difficulty breathing Ear Disease
 Nasal allergies Sinus disease

Have you every had any hematologic/metabolic problems?

- Anemia Bleeding problems
 AIDS virus exposure Blood transfusions
 Autoimmune disease Diabetes
 Thyroid disease Hepatitis

Have you ever been treated for psychiatric / emotional problems or disorders?

- Bronchitis/Pneumonia Asthma
 Eating disorders Other (if yes, please explain) _____

Do you have any medical problems that have not been covered _____

Do you smoke cigarettes? _____ How much _____

Do you drink alcoholic beverages? _____

Do you take recreational drugs? _____

Patient height _____ Patient weight _____

Do You Take Any Diet Medication? _____ (If yes, indicate type and dosage under section II.)

Have You Ever Been Diagnosed With Sleep Apnea? (Pausing in breathing while sleeping) _____

if yes, who is the diagnosing physician? _____

Have you ever had any problems or reactions associated with Anesthesia? _____

II . MEDICAL HISTORY

Name & city of your personal physician _____

Are you presently under the care of a physician for any medical condition? _____

A. SURGICAL HISTORY

Please list all previous surgeries (including cosmetic) also include the surgeon and the year

B. HOSPITALIZATIONS (Others than Surgery)

Illness	Physician/ Date
_____	_____
_____	_____
_____	_____

III . MEDICATIONS & VITAMINS / DIET PILLS

Name of Drug	Strength/Dosage	Condition Treated
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. ALLERGIES: (Please list any allergies to any medications, tapes, or antiseptic cleansers)

IV. FAMILY HISTORY: Please indicate if any immediate family member has had any of the following?

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Anesthetic complications | <input type="checkbox"/> Others |

Date

Patient Signature

Clinic Staff Signature