Patients Personal History

Confidential Information contained herein will not be releases except when you have authorized us to do so. Please answer all questions to the best of your knowledge. Your doctor, in his decisions regarding your care, will use the information provided by you.

Name: ____
Height: _________ Ft: _________ In. Weight __________
Date of last mammogram ______________ Results ____

Do you have or have you had any of the following: (Please Check)

____ Asthma
____ Back Problems
____ Bladder Infection
____ Bleeding Disorder
____ Blood Clots
____ Cancer
____ Chest Pain
____ Chronic Hoarseness
____ Chronic Skin Conditions
____ Chronic Sinus Problems or Nasal Blockage
____ Depression
____ Diabetes
____ Easy Bruising
____ Eating Disorder
____ Epilepsy
____ Glaucoma or Blurry Vision
____ Heart Attack
____ Heart Problems
____ Hepatitis
____ High Blood Pressure
____ HIV+ or AIDS
____ Kidney Disease
____ Latex Allergy
____ Nervous Breakdowns
____ Paralysis of the face
____ Prednisone or Steroid Use
____ Previous Cosmetic Surgery
____ Recurrent Fever Blisters
____ Recurrent Severe Dizziness or Headache
____ Schizophrenia or Psychosis
____ Severe Dryness of the Eyes
____ Shortness of Breath
____ Stomach Ulcers
____ Stroke
____ Tuberculosis

Other serious illnesses which you have had? ____
____
List the name and year of any operation you may have had: ____
____
____

Do you smoke regularly? Y N How much? _________

Do you regularly drink alcohol or beer? Y N How much? _______

Do you take an herbal supplement? Y N (If so, what?) ______________________________________

List the current medications you are taking and the dosage: ____________________________________

____

____

Are you allergic to any medications? Y N (if yes, what?) ______________________________________

Do you take aspirin regularly? Y N Have you had a blood transfusion? Y N Do you have nose bleeds? Y N

Signature: ____ Date: ______________________