

Name of Patient: _____ Age: _____

Referred by: _____ Name of primary care doctor: _____

Reason for seeing doctor: _____

When problem first occurred or date of injury: _____

Describe history of problem or circumstances of injury: _____

If injury: Treated at which Emergency Room: _____

Were x-rays taken: _____ Date of last Tetanus shot: _____

PLEASE ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS.

1. Have you ever suffered from or had: Heart disease Chest disease High Blood pressure
 Diabetes Blood disease Jaundice Kidney disease Glaucoma Cancer

2. Have you recently had: A cold Sore throat Flu
Have you had a recent: Chest x-ray Electrocardiogram(EKG)

3. Have you ever been treated for: Anemia Do you bruise easily

4. Have you ever had problems with: bleeding Blood clots in the legs or lugs

5. Do you suffer from: Hay fever allergies

6. Are you ALLERGIC to any medications, if so which drugs: _____

What kind of reaction do you get if you take them: _____

7. Have you or any relative had a bad reaction to General or local anesthesia? _____ If yes, explain:

8. Have you taken any of the following in the last six months: aspirin tranquilizers water pills blood pressure pills pain pills antihistamines _____

If so, when: _____

9. What medications are you currently taking: _____

10. Do you have any of the following habits: Alcoholic beverages Frequency _____
 Smoking Frequency _____ Recreational Drugs Frequency _____

11. Have you had any previous surgeries including Plastic Surgery: What kind / When / Where

12. Have you ever consulted a professional for emotional problems: _____

13. When was the last time you had a complete medical examination: _____