



PATIENT INFORMATION SHEET

Today's Date _____

Legal Name (Last, First, Initial) _____

Social Security # _____ DOB _____ Marital Status M ____ S ____ W ____ D ____

Address _____ City/State/Zip _____

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

E-mail _____ Where would you prefer to be called (Home, Work, Cell, E-mail)? _____

Pharmacy Name _____ Pharmacy Phone _____

Employer Name _____

Employer Address _____

Referring Physician & Address _____

_____ Phone _____ Specialty _____

Primary Care Physician & Address _____

_____ Phone _____

Emergency Contact Name _____ Relationship _____

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

Do we have permission to speak to this person if necessary regarding your medical consultation? _____

Reason for visit _____ Date of onset _____

Cause of problem (please check one):

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> Auto Accident | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Skin Care |
| <input type="checkbox"/> Other Accident | <input type="checkbox"/> Surgery | <input type="checkbox"/> Wound Care |
| <input type="checkbox"/> Emergency | <input type="checkbox"/> Cosmetic Consult | <input type="checkbox"/> Injections |
| <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Other (Please List:) _____ | |



PAST MEDICAL HISTORY (Please list all medical history regarding you and your immediate family)

Height _____ Weight _____ How long ago was your most recent physical check-up? _____

What is your consumption of the following? Caffeine _____ Tobacco _____ Alcohol _____

PAST SURGICAL HISTORY (Please List)

Operation	Year	Hospital	Surgeon	Anesthesia (Local or General)	Anesthesia Complications?

Serious Illnesses (Please list)

FAMILY HISTORY

Age	State of Health	Has any immediate relative had:
Mother _____	_____	Tuberculosis..... No ___ Yes ___
Father _____	_____	Cancer..... No ___ Yes ___
Brother(s) _____	_____	Type? _____ Relationship? _____
Sister(s) _____	_____	Epilepsy..... No ___ Yes ___
Children _____	_____	Heart Disease..... No ___ Yes ___
_____	_____	High Blood Pressure..... No ___ Yes ___
_____	_____	Lung Disease..... No ___ Yes ___
_____	_____	Kidney Disease..... No ___ Yes ___

FEMALE HISTORY

Do you have regular periods? _____	Blood or Bleeding Disorders... No ___ Yes ___
Have you ever been pregnant? _____	Asthma..... No ___ Yes ___
Are you on birth control? _____	Mental Disease..... No ___ Yes ___
Are you on HRT? _____	Diabetes..... No ___ Yes ___

MEDICATION HISTORY

Are you allergic to any medicines? Yes / No (If Yes, please list below)

Name _____ Reaction _____
 Name _____ Reaction _____
 Name _____ Reaction _____

CURRENT MEDICATIONS

	Name	Dose	Frequency		Name	Dose	Frequency
1.	_____	_____	_____	5.	_____	_____	_____
2.	_____	_____	_____	6.	_____	_____	_____
3.	_____	_____	_____	7.	_____	_____	_____
4.	_____	_____	_____	8.	_____	_____	_____

PERTINENT PREOPERATIVE INFORMATION:

Have you ever reacted badly to being put to sleep for surgery?	No _____	Yes _____
Have you ever had a bad reaction to a local anesthetic?	No _____	Yes _____
Are you allergic to adhesive tape?	No _____	Yes _____
Are you allergic to suture material such as catgut?	No _____	Yes _____
Have you ever had Scarlet Fever or Rheumatic Fever?	No _____	Yes _____
Do you have high blood pressure?	No _____	Yes _____
Do you bleed easily (from cuts, surgery, and tooth extractions)?	No _____	Yes _____
Do you bruise easily?	No _____	Yes _____
Have you required a blood transfusion for surgery?	No _____	Yes _____
Are you a slow or poor healer?	No _____	Yes _____
Do you form large scars or keloids?	No _____	Yes _____
Do you have any skin disease, hives, eczema, or rash?	No _____	Yes _____
Do you have frequent infections or boils?	No _____	Yes _____
Have you taken steroid medications, cortisone, or ACTH?	No _____	Yes _____
Do you have shortness of breath with walking?	No _____	Yes _____
Do you have, or have you had, any significant emotional problems?	No _____	Yes _____
Have you ever had psychiatric care?	No _____	Yes _____
Have you ever been advised to see a psychiatrist?	No _____	Yes _____
Have you ever used illegal drugs?	No _____	Yes _____