Patient: Date of Birth:

Height: Weight: Date of Last Physical:

Drug Allergies:

Other Allergies:

REASON FOR APPOINTMENT:

Previous surgery, including cosmetic surgery (please list)

Operation	Year	Type of Anesthesia

Serious illnesses or hospitalizations, including childbirth (please list)

List all the medications you are now taking, please include dosage/frequency. Include over the counter drugs (ie. Aspirin, vitamins, herbal supplements, etc…)

What is your daily consumption of the following: Tobacco:_____ Alcohol: _____

If you smoked in the past; how much, how long, and when did you quit?

Medical History: Please indicate if you have/had a history of the following:

Have you ever had a blood transfusion?	☐No	☐Yes	Lung Disease	☐No	☐Yes
Malignant hyperthermia	☐No	☐Yes	Kidney Disease	☐No	☐Yes
Radiation therapy to the face	☐No	☐Yes	Heart Disease	☐No	☐Yes
Tuberculosis	☐No	☐Yes	Asthma	☐No	☐Yes
High blood pressure	☐No	☐Yes	Mental illness	☐No	☐Yes
Rheumatic Heart Disease	☐No	☐Yes	Diabetes	☐No	☐Yes
Blood/bleeding disorders	☐No	☐Yes	Depression	☐No	☐Yes
Gastrointestinal/stomach problems	☐No	☐Yes	Cancer	☐No	☐Yes
Hepatitis/Liver disease	☐No	☐Yes	HIV	☐No	☐Yes
Thyroid disease	☐No	☐Yes	Could you be pregnant	☐No	☐Yes

I acknowledge that I have disclosed all of my medical history known to me.

Patient's Signature: _____ **Date:** _____

MD Reviewed _____

I hereby acknowledge that I have read & reviewed the attached copy of the organization's **NOTICE OF PRIVACY PRACTICES**

Patient Name: _____ Date of Birth**:** _____ Social Security #: _____

* Patient Signature: _____ Relationship of Representative (if applicable) **:** _____

At any time you may request a copy of the organization's Notice of Privacy Practices for your records. Please notify staff, if you would like them to supply you with an additional copy.