

HEALTH INFORMATION

NAME OF PATIENT: _____ AGE: _____

PERSONAL PHYSICIAN: _____ GYNECOLOGIST: _____

Date of last physical exam: _____ Date of last mammogram: _____

Are you now, or have you ever, taken any medications on a regular basis? (Aspirin, birth control pills & vitamins included) Please list: _____ Yes _____ No

Are you allergic to, or ever had any reaction to, medications, drugs or local anesthetic? (Novocaine, Xylocaine, Latex, soaps, lotions, tapes, etc.) Please list: _____ Yes _____ No

Have you ever had an operation or been hospitalized for any reason? _____ Yes _____ No

| Date | Reason | Physician |
|-------|--------|-----------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Have you ever had rheumatic fever, heart trouble, heart murmurs, palpitations, irregular heartbeat, chest pains, shortness of breath, swelling of ankles? (please circle) _____ Yes _____ No

Have you ever had high blood pressure, anemia, any blood disorder, excessive bleeding or clotting? _____ Yes _____ No

Have you ever had diabetes, hepatitis, cancer, thyroid disorder, kidney problems, asthma, chronic lung or bronchial disease, or any other serious illness? (please circle) _____ Yes _____ No

Have you ever had a fractured nose, difficulty breathing, nose bleeds, post nasal drip, hay fever, deviated septum, sinus pain? (please circle) _____ Yes _____ No

Have you ever had eye disease, trouble with dryness, soreness, burning, itching, excessive tearing of the eyes? (please circle) _____ Yes _____ No

Have you ever had any psychiatric problems, nervous breakdown, presently or have you ever been under the care of a psychiatrist? _____ Yes _____ No

Do you have any problems with excessive scarring, or have you ever formed a keloid after being cut? _____ Yes _____ No

Do you, or any member of your family, bruise easily or have difficulty with prolonged bleeding when cut or after tooth extraction? _____ Yes _____ No

Do any diseases run in your family? _____ Yes _____ No

Do you have a problem with alcohol or chemical dependency? _____ Yes _____ No

Do you smoke? _____ Yes _____ No How much? _____

Doctor Signature

Date