

**Information For Your Doctor**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

*Please complete the following questionnaire and return it to the office at the time of your first visit.*

Height \_\_\_\_\_ Weight \_\_\_\_\_ (BMI \_\_\_\_\_)

Do you take any medications? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list (include dosage and frequency taken): \_\_\_\_\_

Do you have any allergies to medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list: \_\_\_\_\_

Do you require antibiotics prior to any procedures? Yes \_\_\_\_\_ No \_\_\_\_\_

Please indicate if **YOU** have a history of the following:

High blood pressure	Yes _____	No _____	Cancer	Yes _____	No _____
High cholesterol	Yes _____	No _____	Site: _____		
Chest pain or angina	Yes _____	No _____	Gastroesophageal reflux	Yes _____	No _____
Heart attack	Yes _____	No _____	Liver disease	Yes _____	No _____
Heart rhythm problem	Yes _____	No _____	Hepatitis	Yes _____	No _____
Congestive heart failure	Yes _____	No _____	HIV	Yes _____	No _____
Diabetes	Yes _____	No _____	Kidney disease	Yes _____	No _____
Thyroid problems	Yes _____	No _____	Urinary/Prostate problems	Yes _____	No _____
Asthma	Yes _____	No _____	Blood clots in leg or lung	Yes _____	No _____
COPD/Emphysema	Yes _____	No _____	Bleeding disease	Yes _____	No _____
Pneumonia	Yes _____	No _____	Blood transfusions	Yes _____	No _____
Sleep apnea	Yes _____	No _____	Poor blood flow to legs	Yes _____	No _____
Migraines	Yes _____	No _____	Arthritis	Yes _____	No _____
Seizures	Yes _____	No _____	Do you smoke?	Yes _____	No _____
Stroke	Yes _____	No _____	How much? _____		
Anxiety disorder	Yes _____	No _____	When did you quit? _____		
Depression	Yes _____	No _____	Do you use alcohol?	Yes _____	No _____
Anesthetic Complication	Yes _____	No _____	How much? _____		
Autoimmune disorder	Yes _____	No _____	Do you use illicit drugs?	Yes _____	No _____