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By James D. Weiss, M.D.

PATIENT INFORMATION

Name:_____ Contact Phone:_____

Address:_____ Alternate Phone:_____

City:_____ State:_____ Zip Code:_____

Email:_____

Birth Date:_____ Sex: M F SSN#:_____

Your Pharmacy:_____ Pharmacy Phone:_____

Allergies:_____ _____

_____ _____

_____ _____

Designated Driver Information:

Name:_____

Contact Name:_____

Relationship:_____

In Case of Emergency Contact:

Name:_____ Relationship:_____

Phone:_____ Alternate Phone:_____

Office Use Only

Scheduled Surgery Date:____/____/____

Prescriptions:_____

_____

Called in by:_____ Date: ____/____/

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Current Health Questionnaire

Name:_____ **Date:**_____

Please Indicate if you have had any of the following problems in the last 12 months:

Problem	Yes	No
Weight loss of more than 10 pounds?		
Weight gain of more than 10 pounds?		
Fever over 100.0F?		
Significant changes in mood?		
Significant depression?		
Any significant appetite changes?		
History of Anorexia or Bulimia?		
Do you purge?		
Unusual of severe stress?		
Severe anxiety?		
Significant rashes or other skin changes?		
Moles that have changed?		
Loss of vision?		
Trouble with nose bleeds?		
Facial pain?		
Headaches?		
Dizziness?		
Breast Pain or changes?		
Breas lump?		
Shortness of Breath?		
Wheezing?		
Cough?		
Chest pain or discomfort?		
Heart irregularities?		
Varicose veins?		
Difficulty Swallowing		
Abdominal Pain?		
Nausea or Vomiting?		
HIV+?		

Problem	Yes	No
Heart Burn of Indigestion?		
Constipation?		
Diarrhea?		
Joint pain?		
Problems with Memory		
Numbness or tingling in extremities?		
Women Only:		
Unexplained vaginal bleeding?		
Periods regular?		
Last menstrual period:_____		
Severe cramps or heavy bleeding?		
Any possibility you are pregnant?		

Pre-Procedure Questions	Yes	No
Any problems with local anesthetics?		
Any problems with sedatives?		
Any problems with narcotics/pain meds?		
Any problems with other anesthetic agents?		
Any previous cosmetic procedures by		
other physicians?		
Were you satisfied with the results?		
What kind of procedures?		
_____		
_____		
Do you have any unanswered questions		
about the scheduled procedure for you?		

Office Use Only:

Date: _____ BP:_____ Pulse:_____ Temp:_____

Weight:_____ Height:_____ Resp:_____

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Medical Questionnaire

Name:_____ Date:_____

I. **Allergies:** Please list all medication and/or other allergies that you have.

Allergies	Allergies	Allergies

II. **Medications:** Please list all prescription and non-prescription medications supplements you are taking.

Medication	Dosage	Medication	Dosage

III. **Medical History:** Please list any current medical conditions, previous hospitalizing or surgeries.

Medical Condition	How Long	Medical Condition	How Long

Previous Hospital and/or Surgery	Approx Date	Previous Hospital and/or Surgery	Approx Date

Have you ever experienced any bleeding difficulties after surgery or injury? YES NO
Have you ever experienced other complications after surgery? YES NO

If YES, what kind of complication?_____

IV. **Habits:** **Please answer the following:**

A. Smoking:

Have you ever smoked or used smokeless tobacco? YES NO **If NO proceed to B Below.**
At what age did you start?_____ How many packs/pkgs a day?_____Cigars?_____Pipe?_____
Do you smoke or use smokeless tobacco now? YES NO **If NO, when did you stop?_____years ago.**

B. Alcohol:

Have you ever drank Alcohol? YES NO
Do you drink now? YES NO If no, when did you stop?_____years ago.