

GENERAL INFORMATION SHEET

Patient's Name _____ Age _____ Date _____

1. What medications are you presently taking? Please include all over-the-counter medications, as well as the amounts you take per day.

2. List any medications you are allergic to: _____

3. Have you had any previous surgery including plastic/cosmetic surgery? _____

If so, list what kind of surgery, when you had it, and the doctor's name: _____

4. Have you ever consulted a professional for emotional problems: _____

5. Please check yes or no if you have had or do have any of the following conditions:

	YES	NO
Allergies or Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Chest problems	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood clotting problems	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking a blood thinner?	<input type="checkbox"/>	<input type="checkbox"/>
Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Anemic.....	<input type="checkbox"/>	<input type="checkbox"/>
Have a blood disease?	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Liver problems	<input type="checkbox"/>	<input type="checkbox"/>
Have you had or do you have hepatitis or jaundice?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have muscle weakness?	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Do you take steroids?	<input type="checkbox"/>	<input type="checkbox"/>
Smoke – package(s) per day _____	<input type="checkbox"/>	<input type="checkbox"/>
Drink coffee – cups per day _____	<input type="checkbox"/>	<input type="checkbox"/>
Drink alcoholic beverages – oz. per day _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses/contact lens?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have false teeth or caps?	<input type="checkbox"/>	<input type="checkbox"/>

Weight _____

Height _____

Have you had problems with anesthesia?.....

If yes, please describe _____

Do you have a history of MH (Malignant Hyperthermia)?.....

Do you have relative with a history of MH (Malignant Hyperthermia)?.....

Have you ever been diagnosed with MRSA (Methicillin-resistant Staphylococcus aureus)?.....

6. Your reason for seeing the doctor today: _____

7. Appointment with Dr. _____

