

Andrew P. Giacobbe, M.D., P.C.

Health History

Patient Name: _____ Date: _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Reason for Consultation: _____

Are you under a Doctor's care? _____ For what reason? _____

Have you had any tests or x-rays for this problem? _____

Height _____ Weight _____

(For women): Are you pregnant or trying to become pregnant? _____

Last menstrual period _____

Medical History (mark any that apply)

Heart _____	Any active infection _____	Seizure Disorders _____
Bleeding Disorders _____	Lungs _____	Sleep Disorders _____
Hepatitis _____	Cancer _____	Polycystic Ovary _____
Vascular Disease _____	Diabetes _____	Keloid Scarring _____
Phlebitis _____	Kidneys _____	Cold sores/Fever Blisters _____
Cholesterol _____	Thyroid _____	Herpes I or II _____
Blood Pressure _____	Arthritis _____	Broken Capillaries _____
Blood Transfusions _____	Bruise easily _____	Skin Disease _____
Anemia _____		

Other Illnesses _____

Previous Surgeries _____

Anesthesia Complications self/family _____

List of Current Prescription Medications _____

Over the Counter Medications, Vitamins, Herbals _____

Aspirin on a daily basis? Y__ N__ Dosage _____

Allergies to Medications Y__ N__ Allergy to Latex or surgical gloves? Y__ N__

(If yes please list and state reaction) _____

Social History: Tobacco _____ Alcohol _____ Drugs _____

Family Medical History (if deceased list cause of death)

Father: _____ Mother: _____

Brother: _____ Sister: _____

Reviewed: _____ Andrew P. Giacobbe, M.D. Date: _____

Reviewed by: _____ Date: _____