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	Serious Disorders
Bleeding Disorders	Lungs	Sleep Disorders
Hepatitis	Cancer	Polycystic Ovary
Vascular Disease	Diabetes	Keloid Scarring
Phlebitis/PE	Kidneys	Cold Sores/Fever Blisters
Cholesterol	Thyroid	Herpes I or II
Blood Pressure	Arthritis	Broken Capillaries
Auto-Immune	Bruise Easily	Skin Disease
Anemia	Clotting Disorders	Malignant Hyperthermia

Other Illnesses _____

Previous Surgeries _____

_____

_____

Anesthesia Complications self/family _____

List of Current Prescription Medications _____

_____

Over the Counter Medications, Vitamins, Herbals, Supplements _____

_____

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 by: _____ Date: _____

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