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/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/vaping/nicotine ______________ Alcohol ________________ Drugs ____________

Family Medical History (*if deceased, list cause of death)*

Father: ______________________________ Mother: _________________________________

Brother: _____________________________ Sister: __________________________________

Reviewed by: ____ Date: ________________

Reviewed MD/PA: ____ Date: ________________

Updated 11/11/21