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 _____
Blood Transfusions _____	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:** _____