



**MEDICAL INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Allergies to Medication: \_\_\_\_\_

Are you Allergic to Latex? Y N

Are you Allergic to Adhesives? Y N

Known Food Allergies: \_\_\_\_\_

Current Medications

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you wear contacts? Y N

Do you wear dentures? Y N

Date of Last Physical Exam: \_\_\_\_\_ By Whom? \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Do you Use?	Alcohol	<input type="checkbox"/> Y <input type="checkbox"/> N	How Often?	_____
	Tobacco	<input type="checkbox"/> Y <input type="checkbox"/> N	How Often?	_____
	Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N	How Often?	_____
	Illicit/Street Drugs	<input type="checkbox"/> Y <input type="checkbox"/> N	How Often?	_____

Do you have bleeding problems? Y N

Any difficulties with anesthesia? Y N

Any Medical Problems with: (please explain)

Epilepsy/Seizure	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Eyes	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Ears	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Nose	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Thyroid	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Lungs	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Heart	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Liver/Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Kidneys/Bladder	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Unsightly Scars	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Other	<input type="checkbox"/> Y <input type="checkbox"/> N	_____

**MEDICAL INFORMATION CONTINUED**

Please list any Previous Surgeries or Hospital Admissions Including Childbirth?

Type	Date	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any Current Medical Condition under Treatment by a Physician?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Family History of Medical Problems:

Mother: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Sister: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Father: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Brother: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **PATIENT CONSENT FORM**

I understand that, under the Health Insurance and Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_