HISTORY AND PHYSICAL

Referred by_____ Family Doctor_____
State the specific reason(s) why you made an appointment or state the nature of your injury:
_____

Have you consulted with any other physician regarding this problem(s)? _____yes _____no
Height_____ Weight_____ Weight loss or gain in the past year ____yes ____no _____lbs.
Date of your last physical_____ Did you have an EKG? _____yes ____no Chest X-ray __yes ___no

Do you or any family member have a history of the following conditions?
Tuberculosis __yes __no High blood pressure __yes __no Cancer __yes __no
Lung disease __yes __no Diabetes __yes __no Asthma or emphysema __yes __no
Kidney disease __yes __no Kidney disease __yes __no Epilepsy __yes __no
Heart disease __yes __no Bleeding disorders __yes __no

Please list any serious illness or injuries that you had or have. Please include dates:
_____
Please list any and all surgical procedures that you have had. Be specific.
Date Procedure Doctor Anesthesia (General or Local)
_____
_____
Have you had any significant complications from surgery or anesthesia? _____yes _____ no

Please list all medications, which you are now taking including birth control, water pills, heart medications, sleeping pills, hormones, aspirin, and any other over the counter drugs:
_____
_____
Are you pregnant? _____yes _____ no Date of your last menstrual period_____
How much do you smoke per day?_____ How much coffee/tea do you consume each day? _____
How much alcoholic beverages (including beer/wine) do you consume daily?_____
Are you or have you taken any mind-altering drugs? Please specify_____
Do you have any allergies to food, plants, or medications?_____
Have you or any member of your family ever reacted poorly to being put to sleep? _____yes _____no
Do you require large amounts of anesthesia for medical or dental procedures?_____yes _____no
Have you ever had a reaction to Novocain or Lidocaine? _____yes _____no
Are you allergic to adhesive tape? ____yes ____no Are you allergic to suture material? ____yes ____no
Do you bleed easily? ____yes ____no Are you a "poor" or "slow" healer? ___yes ___no
Do you form keloids? ___yes ___no Have you ever taken steroids? ___yes ___no
Do you get short breath during walking? ___yes ___no Does your religion prohibit transfusions? ___yes__no
Have you ever been advised or under the care of a psychiatrist or psychologist? ___ yes ____no

Have you or do you have any illness or disorders of the following? Please circle if "YES"
Brain (strokes, seizures) Nose, Throat, Sinuses Breasts Stomach Blood Liver
Lungs (asthma, emphysema) Heart or Blood Vessels Intestines Bones & Joints Face(paralysis)
Eyes (glaucoma, dryness, tearing) Ears(hearing loss or impairment) Reproductive system Arms/Legs
Endocrine or Diabetes Urinary Tract Scarlet/Rheumatic Fever Skin (eczema, hives, cysts, boils)
If you circled any of the above, please explain:_____

I certify that the aforementioned information is true to the best of my knowledge and that I have not omitted anything that may affect the course of treatment by Thomas P. Trevisani, M.D.

_____ _____
Signature Date