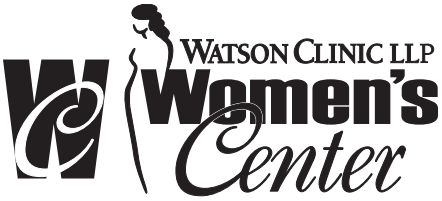
THIS IS AN INFORMATIONAL FORM AND IS NOT A PERMANENT PART OF THE MEDICAL RECORD



Place Patient Label Here

Faeza R. Kazmier, MD
D.J. Nelson, ARNP-C

Patient History Form

Name _____ Birthdate _____ Age _____

Height _____ Weight _____

Address _____

E-mail Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

We would love to know how you found out about Dr. Kazmier: ☐ Website

☐ Previous Patient - *Name* _____ ☐ Doctor - *Name* _____

☐ Magazine - *Which one* _____ ☐ Other: _____

Reason for visit today _____

List any prior surgeries you've had (include year done): _____

_____

_____

Any past anesthesia problems? _____

Any family history of anesthesia problems? _____

Any medical problems (such as diabetes, heart disease, etc): _____

_____

_____

Current medications (include dose and how many times a day you're taking). Please include herbal supplements (like: Garlic, St. John's Wort, Ginko): _____

_____

_____

Social History (marital status, occupation): _____

Do you smoke? _____ If yes, how much _____

Do you drink alcohol? _____ If yes, how much _____

Allergies _____

(Continued on back)

Review of Systems

	YES	NO
General:		
Recent weight change	☐	☐
Poor appetite	☐	☐
Trouble sleeping	☐	☐
Fever	☐	☐
Eyes:		
Glasses/contacts	☐	☐
Loss or change of vision	☐	☐
Glaucoma/cataracts/dry eye	☐	☐
Ears, Nose, Mouth, Throat:		
Hearing aids/hearing loss	☐	☐
Sore throat/strep throat	☐	☐
Nosebleeds	☐	☐
Cardiovascular:		
High blood pressure	☐	☐
Heart murmur	☐	☐
Heart attack	☐	☐
Irregular heartbeat	☐	☐
Mitral valve prolapse	☐	☐
Respiratory:		
Shortness of breath	☐	☐
Asthma	☐	☐
Tuberculosis (TB)	☐	☐
Cough	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Sleep apnea/CPAP mask	☐	☐
Gastrointestinal:		
Ulcers	☐	☐
Nausea/vomiting	☐	☐
Constipation/diarrhea	☐	☐
Vomiting/passing blood	☐	☐
Hemorrhoids	☐	☐
Hepatitis	☐	☐
Jaundice	☐	☐
Cirrhosis	☐	☐
Gallstones	☐	☐
Allergic/Immunlogic:		
Food allergies	☐	☐
HIV infection	☐	☐

	YES	NO
Genitourinary:		
Problems urinating	☐	☐
Difficulty starting stream/dribbling	☐	☐
Pain, burning, frequency	☐	☐
Stress incontinence/leaking	☐	☐
Vaginal dryness	☐	☐
Musculoskeletal:		
Abnormal growths/lumps	☐	☐
Joint swelling/pain	☐	☐
Amputation?	☐	☐
What part? _____		
Skin:		
Psoriasis	☐	☐
Nonhealing, crusting	☐	☐
Skin cancer?	☐	☐
Where? _____		
Breasts:		
Prior biopsy	☐	☐
Lumps	☐	☐
Bloody nipple discharge	☐	☐
Abnormal mammogram	☐	☐
Neurologic:		
Blackouts	☐	☐
Seizures	☐	☐
Headaches	☐	☐
Problems with speech	☐	☐
Confusion	☐	☐
Psychiatric:		
Prior counseling	☐	☐
Medication	☐	☐
Severe depression	☐	☐
Needle anxiety	☐	☐
Endocrine:		
Diabetes	☐	☐
Thyroid problems	☐	☐
Hematologic/Lymphatic:		
Bleeding disorders	☐	☐
Enlarged lymph nodes	☐	☐
History of DVT	☐	☐