

**5<sup>th</sup> AVENUE DERMATOLOGY SURGERY AND LASER CENTER**

**1049 Fifth Avenue, Suite 2B**

**New York, NY 10028**

**(212) 327-2919**

**Health History Questionnaire**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

Business Address: \_\_\_\_\_  
Street City State Zip Code

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed/Widower ( ) Separated

Spouse's Name: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

In Case of Emergency, Please Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**Insurance:**

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Medicare: \_\_\_\_\_

Are you in good health? \_\_\_\_\_ Are you under the care of a physician? Y N

If so, whom? \_\_\_\_\_ Physician's Phone #: \_\_\_\_\_

When was your last physical exam? \_\_\_\_\_ Was everything O.K.? Y N

Please list any drug allergies: \_\_\_\_\_

Please list all medications you are currently taking (Include any over the counter medications): \_\_\_\_\_

Please list any current or past medical illnesses with dates: \_\_\_\_\_

Please list all hospitalizations, injuries or accidents with dates: \_\_\_\_\_

Please list any surgeries (including cosmetic) with dates: \_\_\_\_\_

Please list any other fact of a medical or other nature that you feel you should make known before you undergo surgery: \_\_\_\_\_

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If Female, are you pregnant or planning a pregnancy? Y N  
 Do you have any problems associated with your menstrual period? Y N  
 Are you nursing? Y N Are you taking birth control pills? Y N

Any significant heredity disorders (Excessive Bleeding): \_\_\_\_\_  
 Do you smoke? Y N If so, how much \_\_\_\_\_  
 Do you drink alcohol? ( ) None ( ) Occasionally ( ) Moderately ( ) Excessively  
 Do you wear contacts? Y N Do you wear removable dental appliances? Y N

**Please answer the following questions**

Do you have a history of chronic skin condition?.....Y N  
 Do you have a personal or family history of Cancer?.....Y N  
 Do you have herpes breakouts?.....Y N  
 Do you have asthma or any chronic lung or bronchial condition?.....Y N  
 Do you have a history of cardiovascular disease?.....Y N  
 Do you have damaged or artificial heart valves, including murmurs and prolapse?.....Y N  
 Do you have high blood pressure or cholesterol?.....Y N  
 Do you have abdominal problems including colitis and peptic ulcers?.....Y N  
 Do you have a history of hepatitis?.....Y N  
 Any trouble with your kidneys, bladder or reproductive system?.....Y N  
 Any bone joint or muscular trouble?.....Y N  
 Do you have any of the following: diabetes, epilepsy, or high blood pressure?.....Y N  
 Are you HIV positive?.....Y N  
 Have you ever been under the care of a psychiatrist or psychologist?.....Y N  
 Do you bleed or bruise easily?.....Y N  
 Have you ever had a blood transfusion?.....Y N  
 Have you ever had excessive bleeding following surgery or dental work?.....Y N  
 (For Women) Do your periods last longer than 4 or 5 days?.....Y N  
 Have you ever had a poor scarring or keloid formation following an  
 operation or vaccination?.....Y N  
 Did you ever have a bad recovery following a prior surgery?.....Y N  
 Have you ever been dissatisfied with the treatment you received from a doctor?..... Y N  
 If yes, please explain: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Referred by:  friend/other \_\_\_\_\_  article  internet  ad

I certify that I have read and understand the questions above. I acknowledge that the questions about the above have been answered with full disclosure of my medical history. I will not hold my surgeon, or any of his/her staff responsible for any errors or omissions that I have made in completing this Health History Questionnaire.

**I am aware that there will be an office fee for all cosmetic and medical consultations unless otherwise specified by our staff prior to the visit.**

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