

MEDICAL HISTORY

Please specifically give the reason for you visit: _____

Please list all drug-related allergies or intolerances: _____

Are you under a doctor's care? _____ Name: _____

Phone: _____

Do we have permission to contact your doctor or allergist? Yes No

Do you have a history of (circle correct answer):

Heart trouble	Yes No	Nasal allergy	Yes No	Do you smoke cigarettes	Yes No
Diabetes	Yes No	Post-nasal discharge	Yes No	Dry or itchy eyes	Yes No
Ulcers	Yes No	Sinus infections	Yes No	Burning of the eyes	Yes No
Anemia	Yes No	Nose bleeds	Yes No	Do you drink alcohol?	Yes No
Asthma	Yes No	Headaches	Yes No	0-1 drinks per day	
Pulmonary trouble	Yes No	Hepatitis	Yes No	2-3 drinks per day	
High blood pressure	Yes No	Difficulty breathing	Yes No	4 + drinks per day	
Positive HIV/AIDS	Yes No	through nose		Height _____	Weight _____

List all medications you are currently taking (including over the counter medicines, aspirin or aspirin containing medicines, birth control pills or Vitamin E), along with the dosage: _____

List all previous operations or major illnesses you have had, along with approximate dates: _____

Have you had any exposure to HIV through prior sexual history, surgery, transfusions of IV drug use?	Yes No
Have you had a reaction to anesthetics?	Yes No
Do you have a history of increased bleeding tendency?	Yes No
Have you ever had a blood transfusion?	Yes No
Have you ever been under the care of a psychiatrist or had a nervous breakdown?	Yes No
Do you wear glasses?	Yes No
Do you wear contacts?	Yes No
Do you have a history of bad scarring?	Yes No
If yes, where? _____	

List any other important information _____

I consent to photographic documentation of my treatment. These images can be used for medical, scientific, educational, or commercial purposes and are the property of Dr. Orloff.

This information is correct and complete to the best of my knowledge:

Signature of patient

Date