LASKY CLINIC
BEVERLY HILLS

PATIENT INFORMATION

Name _____ Age _____ Sex _____ Date _____

Preferred Designation _____ SS# _____ Driver's Lic# _____

Birthdate _____ Single ☐ Married ☐ Widowed ☐ Divorced ☐

Address _____

City _____ State _____ Zip _____

Home (_____) _____ Work (_____)_____ Cell Phone (_____)_____

Occupation: _____ email: _____

Who is responsible party: _____ Employer:_____

Person to contact in case of emergency:_____ (_____)_____

Referred by:_____

I will be consulting with Dr. _____ today and the purpose of this consult is to discuss _____

I. MEDICAL QUESTIONNAIRE: (Please indicate with a "X " all that apply)

Have you ever had any heart problems?
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack
- ☐ Irregular heartbeat
- ☐ Heart murmur
- ☐ Shortness of breath
- ☐ Chest pain/tightness

Have you ever had any gastrointestinal problems?
- ☐ Ulcers
- ☐ Gastritis
- ☐ Colitis
- ☐ Diverticulitis

Have you ever had any lung problems?
- ☐ Bronchitis/Pneumonia
- ☐ Asthma
- ☐ Heart attack
- ☐ Tuberculosis
- ☐ Other

Have you ever had any musculosketal/ neurological problems?
- ☐ Convulsions
- ☐ Epilepsy
- ☐ Headaches
- ☐ Arthritis
- ☐ Other

Have you ever had any eye, ear, nose or throat problems?
- ☐ Dry eyes
- ☐ Blurred vision
- ☐ Glaucoma
- ☐ Nosebleeds
- ☐ Corrective lenses
- ☐ Difficulty breathing
- ☐ Ear Disease
- ☐ Nasal allergies
- ☐ Sinus disease

Have you ever had any hematologic/metabolic problems?
- ☐ Anemia
- ☐ Bleeding problems
- ☐ AIDS virus exposure
- ☐ Blood transfusions
- ☐ Autoimmune disease
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Hepatitis

Have you ever been treated for psychiatric / emotional problems or disorders?
- ☐ Depression
- ☐ Anxiety
- ☐ Eating disorders
- ☐ Other (if yes, please explain) _____

Do you have any medical problems that have not been covered _____

Do you smoke cigarettes?_____ How much _____

Do you drink alcoholic beverages ?_____

Do you take recreational drugs? _____

Patient height_____ Patient weight _____

Do You Take Any Diet Medication? _____ (If yes, indicate type and dosage under section II.)

Have You Ever Been Diagnosed With Sleep Apnea? (Pausing in breathing while sleeping)_____

if yes, who is the diagnosing physician? _____

Have you ever had any problems or reactions associated with Anesthesia? _____

II . MEDICAL HISTORY

Name & city of your personal physician _____

Are you presently under the care of a physician for any medical condition?_____

_____

A. SURGICAL HISTORY

Please list all previous surgeries (including cosmetic) also include the surgeon and the year

_____

_____

_____

B. HOSPITALIZATIONS (Others than Surgery)

Illness	Physician/ Date
_____	_____
_____	_____
_____	_____

III . MEDICATIONS & VITAMINS / DIET PILLS

Name of Drug	Strength/Dosage	Condition Treated
_____		
_____		
_____		

IV. ALLERGIES: (Please list any allergies to any medications, tapes, or antiseptic cleansers)

_____

_____

IV. FAMILY HISTORY: Please indicate if any immediate family member has had any of the following?

☐ Heart disease ☐ Bleeding disorder ☐ Diabetes

☐ Autoimmune disease ☐ Anesthetic complications ☐ Others

_____ _____

Date Patient Signature

_____

Clinic Staff Signature