HEALTH QUESTIONNAIRE

PAST MEDICAL HISTORY

GENERAL HEALTH: GOOD FAIR POOR IF NOT GOOD, PLEASE EXPLAIN: _____

SERIOUS ILLNESS (PLEASE LIST) _____

HEIGHT _____ WEIGHT _____ WHEN DID YOU LAST HAVE: EKG? _____ CHEST X-RAY? _____

NAME OF FAMILY DOCTOR: _____

ADDRESS _____

PREVIOUS SURGERY (PLEASE LIST)

OPERATION	YEAR	GENERAL OR LOCAL

HAVE YOU EVER HAD ANY COMPLICATION OR AFTER EFFECTS FROM ANY OF THESE OPERATIONS? NO YES

IF YES, PLEASE EXPLAIN: _____

FAMILY HISTORY

	AGE	STATE OF HEALTH (OR CAUSE OF DEATH)
MOTHER		
FATHER		
BROTHER(S)		
SISTERS		
CHILDREN		

HAVE YOU EVER HAD:

BLEEDING DISORDER	_____	HIGH BLOOD PRESSURE	_____
TUBERCULOSIS	_____	LUNG DISEASE	_____
CANCER	_____	MENTAL DISEASE	_____
DIABETES	_____	HEPATITIS	_____
EPILEPSY	_____	AIDS OR ARC	_____
HEART DISEASE	_____		

ARE YOU ALLERGIC TO ANY MEDICATIONS? NO _____ YES _____ IF YES, WHICH ONE(S): _____

MEDICATIONS, DRUGS: WHAT IS YOUR APPROXIMATE DAILY CONSUMPTION OF THE FOLLOWING?

TOBACCO _____ ALCOHOL _____ COFFEE OR TEA _____ SOCIAL DRUG (MARIJUANA, COCAINE, ETC.) _____

PLEASE LIST ALL THE MEDICATION YOU ARE TAKING (INCLUDING BLOOD THINNERS, ASPIRIN, BUFFERIN, BIRTH CONTROLL PILLS, WATER PILLS, BLOOD PRESSURE PILLS, TRANQUILIZERS, HORMONES, ETC.)

_____

CONSENT TO TAKING PHOTOGRAPHS

IN CONNECTION WITH THE MEDICAL SERVICES WHICH I AM RECEIVING FROM DR. VINCENT LEPORE OR DR. DARYL HOFFMAN, I CONSENT THAT PHOTOGRAPHS MAY BE TAKEN OF ME OR PARTS OF MY BODY, UNDER THE FOLLOWING CONDITIONS:

1. THE PHOTOGRAPHS MAY BE TAKEN ONLY WITH THE CONSENT OF MY PHYSICIAN AND EITHER BY MY PHYSICIAN OR A PERSON OF HIS CHOICE.
2. THESE PHOTOGRAPHS SHALL BE USED FOR MEDICAL RECORDS ONLY, UNLESS, IN THE JUDGEMENT OF MY PHYSICIAN, MEDICAL RESEARCH, EDUCATION, OR SCIENCE WILL BENEFIT BY THEIR USE. IN THAT EVENT, I AGREE THAT THEY MAY BE USED FOR SUCH PURPOSES, PROVIDED THAT MY IDENTITY IS NOT REVEALED BY THE PHOTOGRAPHS.

✘ _____ _____

PATIENT DATE