GEORGE H. SANDERS, M.D., APC

NAME:________________________________Age:____Sex:____ WT:_______ HT:___‘ ___“ MARITAL STATUS_____

HAVE YOU HAD OR DO YOU STILL HAVE:	YES	NO
1. COLD OR COUGH WITHIN THE LAST TWO WEEKS	___	___
2. BREATHING PROBLEMS (ASTHMA, ETC)	___	___
3. CHEST PAINS OR ANGINA	___	___
4. HEART PROBLEMS	___	___
5. PALPITATIONS, IRREGULAR OR FAST HEARTBEAT	___	___
6. SHORTNESS OF BREATH AT ANY TIME	___	___
7. SLEEP APNEA	___	___
8. HIGH BLOOD PRESSURE	___	___
9. ANY CIRCULATORY PROBLEMS	___	___
10. BLOOD CLOTS OR CLOTTING DISORDERS OR FAMILY HISTORY OF THIS	___	___
11. BLOOD DISEASE (ANEMIA, ETC)	___	___
12. BLEEDING PROBLEMS	___	___
13. ANY IMMUNE PROBLEMS OR DISEASE	___	___
14. LIVER DISEASE (HEPATITIS, JAUNDICE, ETC)	___	___
15. STOMACH PROBLEMS (ULCERS, ETC)	___	___
16. INTESTINAL PROBLEMS	___	___
17. NECK OR BACK PAIN OR INJURIES	___	___
18. SEIZURES	___	___
19. HEADACHES	___	___
20. STROKE OR TEMPORARY PARALYSIS	___	___
21. PSYCHIATRIC OR PSYCHOLOGICAL TREATMENT	___	___
22. ANY VISUAL OR EYE PROBLEMS	___	___
23. GLASSES OR CONTACT LENSES	___	___
24. DIABETES	___	___
25. THYROID PROBLEMS	___	___
26. KIDNEY OR BLADDER PROBLEMS	___	___
27. ANY PROBLEMS DURING PREGNANCY	___	___
28. PROBLEMS WITH ALCOHOL OR DRUG ABUSE	___	___
29. WEIGHT CHANGE IN THE PAST YEAR	___	___
30. CONNECTIVE TISSUE DISEASE (SCLERODERMA, LUPUS, RHEUMATOID ARTHRITIS)	___	___
31. COLD SORES OR OTHER HERPES INFECTIONS	___	___
32. CHANGE IN ANY SKIN GROWTH (MOLES, ETC)	___	___

HAVE YOU HAD OR DO YOU STILL HAVE:	YES	NO
33. ANY HEALING OR SCARRING PROBLEM	___	___
34. CANCER OF ANY TYPE	___	___
35. ALLERGIES OR UNFAVORABLE REACTIONS TO ANY MEDICATIONS OR SUBSTANCES (PLEASE LIST) ________________________________ * ________________________________	___	___
36. SURGERY (PLEASE LIST TYPE AND DATES) INCLUDE ALL COSMETIC SURGERY ________________________________ ________________________________ * ________________________________	___	___
37. PLEASE LIST ANY PILLS OR MEDICATIONS WITHIN THE LAST THREE YEARS ________________________________ ________________________________ * ________________________________	___	___
38. DO YOU TAKE ASPIRIN, ADVIL OR ANY OTHER ANTI-INFLAMMATORY MEDICATION	___	___
39. DO YOU TAKE ANY HORMONAL MEDICATION, PRESCRIPTION OR OVER THE COUNTER	___	___
40. HAVE YOU EVER SMOKED IF YES, HOW MUCH PER DAY ____________ FOR HOW MANY YEARS_________ IF YOU HAVE QUIT, WHEN _______________	___	___
41. DO YOU DRINK ALCOHOL HOW MUCH PER WEEK ________________	___	___
42. WHEN WAS YOUR LAST PHYSICAL EXAM ________________		
43. WHEN WAS YOU LAST MENSTRUAL PERIOD ________________		
44. HAVE YOU BEEN TOLD YOU HAVE ANY OTHER DISEASES NOT MENTIONED ABOVE? IF YES, PLEASE LIST:________________________ ________________________________ * ________________________________	___	___

REFERRED BY: ________________________________ REASON FOR YOUR VISIT: ________________________________

IS IT OKAY WITH YOU TO SEND A THANK YOU NOTE TO THE PERSON WHO REFERRED YOU TO US? ___YES ___NO

WHO IS YOUR PERSONAL PHYSICIAN?______________________________ CITY OF HIS/HER PRACTICE:__________________________

PERSONAL INFORMATION INITIAL CONSULTATION

* IF YOU NEED ADDITIONAL SPACE, CHECK HERE _____ AND USE THE BACK OF THIS FORM