

GEORGE H. SANDERS, M.D., APC

NAME: _____ Age: _____ Sex: _____ HT: _____' _____" WT: _____ LBS

<u>HAVE YOU HAD OR DO YOU STILL HAVE :</u>	<u>YES</u>	<u>NO</u>	<u>HAVE YOU HAD OR DO YOU STILL HAVE :</u>	<u>YES</u>	<u>NO</u>
1. COLD OR COUGH WITHIN THE LAST TWO WEEKS	___	___	35. CANCER OF ANY TYPE	___	___
2. BREATHING PROBLEMS (ASTHMA, ETC)	___	___	36. ALLERGIES OR UNFAVORABLE REACTIONS TO ANY MEDICATIONS OR SUBSTANCES (PLEASE LIST)	___	___
3. CHEST PAINS OR ANGINA	___	___	_____		
4. HEART PROBLEMS	___	___	_____		
5. PALPITATIONS, IRREGULAR OR FAST HEARTBEAT	___	___	37. SURGERY (PLEASE LIST TYPE AND DATES)	___	___
6. SHORTNESS OF BREATH AT ANY TIME	___	___	PLEASE INCLUDE ALL COSMETIC SURGERY		
7. SLEEP APNEA, USE CPAP	___	___	_____		
8. HIGH BLOOD PRESSURE	___	___	_____		
9. ANY CIRCULATORY PROBLEMS	___	___	38. PLEASE LIST ANY PILLS OR MEDICATIONS TAKEN REGULARLY WITHIN THE LAST THREE YEARS	___	___
10. BLOOD CLOTS OR CLOTTING DISORDERS OR FAMILY HISTORY OF THIS	___	___	_____		
11. BLOOD DISEASE (ANEMIA, ETC)	___	___	_____		
12. BLEEDING PROBLEMS	___	___	39. DO YOU TAKE ASPIRIN, ADVIL, NSAID'S, OR ANY OTHER ANTI-INFLAMMATORY MEDICATION?	___	___
13. ANY IMMUNE PROBLEMS OR DISEASE	___	___	40. DO YOU USE A VAGINAL CONTRACEPTIVE RING, TAKE ANY HORMONAL MEDICATION, BIRTH CONTROL PILLS, PRESCRIPTION, OR OVER-THE-COUNTER MEDICATIONS?	___	___
14. LIVER DISEASE (HEPATITIS, JAUNDICE, ETC)	___	___	41. HAVE YOU EVER SMOKED CIGARETTES, ELECTRONIC CIGARETTES, HOOKAH PIPES, OR MARIJUANA?	___	___
15. STOMACH PROBLEMS (ULCERS, ETC)	___	___	IF YES, HOW MUCH PER DAY? _____		
16. INTESTINAL PROBLEMS	___	___	FOR HOW MANY YEARS? _____		
17. NECK OR BACK PAIN OR INJURIES	___	___	IF YOU HAVE QUIT, WHEN? _____		
18. SEIZURES	___	___	42. DO YOU DRINK ALCOHOL ?	___	___
19. HEADACHES	___	___	IF YES, HOW MUCH PER WEEK? _____		
20. STROKE OR TEMPORARY PARALYSIS	___	___	43. WHEN WAS YOUR LAST PHYSICAL EXAM?	_____	
21. PSYCHIATRIC OR PSYCHOLOGICAL TREATMENT	___	___	44. WHEN WAS YOUR LAST MENSTRUAL PERIOD?	_____	
22. ANY VISUAL OR EYE PROBLEMS, DRYNESS	___	___	45. HAVE YOU BEEN TOLD YOU HAVE ANY OTHER DISEASES NOT MENTIONED ABOVE? IF YES, PLEASE LIST: _____	___	___
23. GLASSES OR CONTACT LENSES	___	___	_____		
24. DIABETES	___	___	_____		
25. THYROID PROBLEMS	___	___	* NEED ADDITIONAL SPACE? CHECK HERE ___ AND USE THE BACK OF THIS PAGE		
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)	___	___			
33. SKIN INFECTIONS, NASAL SORES, OR MRSA INFECTIONS	___	___			
34. ANY HEALING OR SCARRING PROBLEM	___	___			

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: _____