GEORGE H. SANDERS, M.D., APC

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

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, OR HEART PROBLEMS	___	___
4. PALPITATIONS, IRREGULAR OR FAST HEARTBEAT	___	___
5. SHORTNESS OF BREATH AT ANY TIME	___	___
6. SLEEP APNEA, USE OF CPAP	___	___
7. HIGH BLOOD PRESSURE	___	___
8. ANY CIRCULATORY PROBLEMS	___	___
9. BLOOD CLOTS OR CLOTTING DISORDERS OR FAMILY HISTORY OF THIS	___	___
10. BLOOD DISEASE (ANEMIA, ETC)	___	___
11. BLEEDING PROBLEMS	___	___
12. ANY IMMUNE PROBLEMS OR DISEASE	___	___
13. LIVER DISEASE (HEPATITIS, JAUNDICE, ETC)	___	___
14. STOMACH PROBLEMS (ULCERS, ETC)	___	___
15. INTESTINAL PROBLEMS	___	___
16. NECK OR BACK PAIN OR INJURIES	___	___
17. SEIZURES	___	___
18. HEADACHES	___	___
19. STROKE OR TEMPORARY PARALYSIS	___	___
20. PSYCHIATRIC OR PSYCHOLOGICAL TREATMENT	___	___
21. ANY VISUAL OR EYE PROBLEMS, DRYNESS	___	___
22. GLASSES OR CONTACT LENSES	___	___
23. DIABETES	___	___
24. THYROID PROBLEMS	___	___
25. KIDNEY OR BLADDER PROBLEMS	___	___
26. ANY PROBLEMS DURING PREGNANCY	___	___
27. PROBLEMS WITH ALCOHOL OR DRUG ABUSE	___	___
28. WEIGHT CHANGE IN THE PAST YEAR	___	___
29. CONNECTIVE TISSUE DISEASE (SCLERODERMA, LUPUS, RHEUMATOID ARTHRITIS)	___	___
30. COLD SORES OR OTHER HERPES INFECTIONS	___	___
31. CHANGE IN ANY SKIN GROWTH (MOLES, ETC)	___	___
32. SKIN INFECTIONS, NASAL SORES, OR MRSA INFECTIONS	___	___
33. ANY HEALING OR SCARRING PROBLEM	___	___
34. CANCER OF ANY TYPE	___	___

HAVE YOU HAD OR DO YOU STILL HAVE :	YES	NO
35. ALLERGIES OR UNFAVORABLE REACTIONS TO ANY MEDICATIONS OR SUBSTANCES (PLEASE LIST) _____ _____	___	___
36. HAVE YOU EVER HAD FILLERS, BOTOX, LASER, OR NON-SURGICAL SKIN TIGHTENING	___	___
37. SURGERY (PLEASE LIST TYPE AND DATES) PLEASE INCLUDE ALL COSMETIC SURGERY _____ _____ _____	___	___
38. PLEASE LIST ANY PILLS OR MEDICATIONS TAKEN REGULARLY WITHIN THE LAST THREE YEARS _____ _____ _____	___	___
39. DO YOU TAKE ASPIRIN, ADVIL, NSAID'S, OR ANY OTHER ANTI-INFLAMMATORY MEDICATION?	___	___
40. DO YOU USE A VAGINAL CONTRACEPTIVE RING, TAKE ANY HORMONAL MEDICATION, BIRTH CONTROL PILLS, PRESCRIPTION, OR OVER-THE-COUNTER MEDICATIONS?	___	___
41. HAVE YOU EVER SMOKED CIGARETTES, ELECTRONIC CIGARETTES, HOOKAH PIPES, OR MARIJUANA? IF YES, HOW MUCH PER DAY? _____ FOR HOW MANY YEARS? _____ IF YOU HAVE QUIT, WHEN? _____	___	___
42. DO YOU DRINK ALCOHOL ? IF YES, HOW MUCH PER WEEK? _____	___	___
43. WHEN WAS YOUR LAST PHYSICAL EXAM?	_____	
44. WHEN WAS YOUR LAST MENSTRUAL PERIOD?	_____	
45. HAVE YOU BEEN TOLD YOU HAVE ANY OTHER DISEASES NOT MENTIONED ABOVE? IF YES, PLEASE LIST:_____ _____ _____	___	___

* NEED ADDITIONAL SPACE? CHECK HERE ___ AND USE THE BACK OF THIS PAGE

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:_____