



ROBERT B POLLACK, MD, FACS, INC.
HEALTH INFORMATION

Today's Date ____ / ____ / ____

PATIENT INFORMATION

Patient's First Name		MI	Last Name		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Home Phone No.
					<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	()
Street Address				City	State	ZIP	Cell Phone / Pager No.
							()
E-mail	Sex	Birth Date		OK to leave message on your answering machine?		Work Phone No.	
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No		()	
Occupation			Employer			Work Phone Extension	
How did you find out about our office? (Please check one box)							
<input type="checkbox"/> Doctor		<input type="checkbox"/> Family/Friend			<input type="checkbox"/> Internet		
		<input type="checkbox"/> Seminar		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other	

What treatment or procedure are you interested in?

MEDICAL HISTORY

Height	Weight	Is your general health good?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Previous Surgery	Operation	Date	Complications?		

Current Medications Examples: Antibiotics, birth control, vitamins, aspirin, asthma inhalers

List any medications which cause allergies, bad reactions, side effects

Do you usually take two or more alcoholic drinks a day? Yes No

Do you smoke? Yes No If yes, how much?

Have you ever been told not to donate blood? Yes No If yes, what was the reason

(OVER)

Have you had any of the following

- | | | | | | |
|---------------------------|------------------------------|-----------------------------|--------------------------|------------------------------|-----------------------------|
| Frequent Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swelling of ankles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Seizures/Convulsions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dry Eyes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mouth or Cold Sores | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thyroid Problems / Goiter | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Anemia (thin blood) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Attack | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest Pain (angina) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bleeding Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Troubles | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis/ Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Irregular Heartbeat | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | | | Blood Clots | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Women Only:

- Do you use birth control? Yes No
- Are you pregnant? Yes No
- Do you have children? Yes No

Ages: _____

CONSENT

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Robert B Pollack, MD, FACS, Inc to release any information to my insurance company required to process my claims.

In connection with the medical services which I am receiving I understand that photography is important in planning and evaluation. I give permission for photographs or computer images to be taken of me for the purposes of documentation in my medical records only. There shall not be any other use of the images unless I sign a separate authorization in the future.

By signing this form, I acknowledge I have received or been offered a copy of La Jolla Professional Plastic Surgery's Notice of Privacy Policy and I consent to the use and disclosure of my protected health information for treatment, payment, and healthcare operations as described in the policy. If I do not sign this consent, or later revoke it, Robert B Pollack, MD may decline to provide treatment to me.

X

PATIENT SIGNATURE

DATE

PRINT YOUR NAME

Witnessed (Office Staff)