Robert B Pollack, MD, FACS, Inc.

Health Information

Today's Date _____/_____/_____

PATIENT INFORMATION

Patient's First Name	MI	Last Name	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Home Phone No. ( )
Street Address		City	State ZIP	Cell Phone / Pager No. ( )
E-mail	Sex ❑ M ❑ F	Birth Date / /	OK to leave message on your answering machine? ❑ Yes ❑ No	Work Phone No. ( )
Occupation		Employer		Work Phone Extension

How did you find out about our office? (Please check one box)

❑ Doctor _____ ❑ Family/Friend _____ ❑ Internet

❑ Seminar ❑ Yellow Pages ❑ Other _____

What treatment or procedure are you interested in?

MEDICAL HISTORY

Height	Weight	Is your general health good? ❑ Yes ❑ 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	❑ Yes	❑ No	Swelling of ankles	❑ Yes	❑ No
Seizures/Convulsions	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No
Dry Eyes	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No	Shortness of Breath	❑ Yes	❑ No
Mouth or Cold Sores	❑ Yes	❑ No	Asthma	❑ Yes	❑ No
Thyroid Problems / Goiter	❑ Yes	❑ No	Kidney Problems	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No	Anemia (thin blood)	❑ Yes	❑ No
Heart Attack	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No
Chest Pain (angina)	❑ Yes	❑ No	Bleeding Problems	❑ Yes	❑ No
Heart Troubles	❑ Yes	❑ No	Hepatitis/ Liver Disease	❑ Yes	❑ No
Irregular Heartbeat	❑ Yes	❑ No	Cancer	❑ Yes	❑ No
			Blood Clots	❑ Yes	❑ No

Women Only:

Do you use birth control? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No

Do you have children? ❑ Yes Ages: ❑ No

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)