STEVENS

LESLIE HOWARD STEVENS, M.D., F.A.C.S.

PATIENT INFORMATION

Name _____ Age _____ Sex _____ Date _____

Preferred Designation _____ SSN# _____

Birthdate _____ Single ☐ Married ☐ Widowed ☐ Divorced ☐

Address _____

City _____ State _____ Zip _____

Home (_____) _____ Work (_____)_____ Cell Phone (_____)_____

Occupation: _____ Email: _____

Who is responsible party: _____ Employer:_____

Person to contact in case of emergency:_____ (_____) _____

Referred by: _____

I will be consulting with Dr. Stevens today and the purpose of this consult is to discuss _____

I. MEDICAL QUESTIONNAIRE: (Please indicate with a "X " all that apply)

Have you ever had any heart problems?

☐ High blood pressure ☐ Low blood pressure
☐ Heart attack ☐ Irregular heartbeat
☐ Heart murmur ☐ Shortness of breath
☐ Chest pain/tightness

Have you ever had any gastrointestinal problems?

☐ Ulcers ☐ Gastritis
☐ Colitis ☐ Diverticulitis

Have you ever had any lung problems?

☐ Bronchitis/Pneumonia ☐ Asthma
☐ Heart attack ☐ Tuberculosis
☐ Other

Have you ever had any musculosketal/ neurological problems?

☐ Convulsions ☐ Epilepsy
☐ Headaches ☐ Arthritis
☐ Other

Have you ever had any eye, ear, nose or throat problems?

☐ Dry eyes
☐ Blurred vision ☐ Glaucoma
☐ Nosebleeds ☐ Corrective lenses
☐ Difficulty breathing ☐ Ear Disease
☐ Nasal allergies ☐ Sinus disease

Have you ever had any hematologic/metabolic problems?

☐ Anemia ☐ Bleeding problems
☐ AIDS virus exposure ☐ Blood transfusions
☐ Autoimmune disease ☐ Diabetes
☐ Thyroid disease ☐ Hepatitis

Have you ever been treated for psychiatric / emotional problems or disorders?

☐ Depression ☐ Anxiety
☐ Eating disorders ☐ Other (if yes, please explain) _____

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Office: 310.556.1003 Facsimile: 310.556.1088
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Do you have any medical problems that have not been covered _____

Do you smoke cigarettes?_____ How much _____

Do you drink alcoholic beverages ?_____

Do you take recreational drugs? _____

Height_____ Weight _____

Do You Take Any Diet Medication? _____ (If yes, indicate type and dosage under section II.)

Have You Ever Been Diagnosed With Sleep Apnea? (Pausing in breathing while sleeping)_____

if yes, who is the diagnosing physician? _____

Have you ever had any problems or reactions associated with Anesthesia? _____

II . MEDICAL HISTORY

Name & city of your personal physician _____

Are you presently under the care of a physician for any medical condition?_____

_____

A. SURGICAL HISTORY

Please list all previous surgeries (including cosmetic) also include the surgeon and the year

_____

_____

_____

B. HOSPITALIZATIONS (Others than Surgery)

Illness	Physician/ Date
_____	_____
_____	_____
_____	_____

III . MEDICATIONS & VITAMINS / DIET PILLS

Name of Drug	Strength/Dosage	Condition Treated
_____		
_____		
_____		

IV. ALLERGIES: (Please list any allergies to any medications, tapes, or antiseptic cleansers)

☐ None _____

_____

V. FAMILY HISTORY: Please indicate if any immediate family member has had any of the following?

☐ Heart disease ☐ Bleeding disorder ☐ Diabetes ☐ None

☐ Autoimmune disease ☐ Anesthetic complications ☐ Others

_____ _____

Date Patient Signature

_____

Clinic Staff Signature

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