

PATIENT MEDICAL INFORMATION

ALBERT DABBAH, MD, PA

HEIGHT: _____ WEIGHT: _____

DRUG ALLERGIES: NONE PENICILLIN IODINE CONTRAST SULFA LATEX

OTHER ALLERGIES: _____

SMOKING HISTORY: YES NO WHEN STARTED: _____ WHEN YOU QUIT: _____

HOW MUCH DO YOU SMOKE: _____ DO YOU USE VAPOR CIGARETTES OR PIPE: Y N

NICOTINE GUM OR PATCH: Y N CIGARS: Y N

MEDICATIONS: PLEASE LIST ALL PRESCRIPTION AND NON PRESCRIPTION MEDICATIONS YOU TAKE INCLUDING SUPPLEMENTS, HERBALS, HORMONES AND DIET PILLS

YOUR PERSONAL MEDICAL HISTORY

- | | | |
|--|--|---|
| <input type="radio"/> ASTHMA | <input type="radio"/> HEART DISEASE | <input type="radio"/> PERIPHERAL VASCULAR DISEASE |
| <input type="radio"/> LUNG PROBLEMS | <input type="radio"/> HEART ATTACK | <input type="radio"/> PREGNANT |
| <input type="radio"/> AUTOIMMUNE DISORDERS | <input type="radio"/> HEPATITIS | <input type="radio"/> SEIZURES |
| <input type="radio"/> CONNECTIVE TISSUE DISEASES | <input type="radio"/> HIV/AIDS | <input type="radio"/> SKIN CANCER |
| <input type="radio"/> ARTHRITIS | <input type="radio"/> HIGH BLOOD PRESSURE | <input type="radio"/> STROKE |
| <input type="radio"/> BLEEDING DISORDERS | <input type="radio"/> KIDNEY PROBLEMS | <input type="radio"/> THYROID DISEASE |
| <input type="radio"/> DEMENTIA | <input type="radio"/> LIVER DISEASE | <input type="radio"/> CANCER: TYPE _____ |
| <input type="radio"/> DIABETES | <input type="radio"/> HERPES OR FEVER BLISTERS | <input type="radio"/> BLOOD CLOTS OR THROMBOSIS |
| <input type="radio"/> DRY EYE CONDITION | <input type="radio"/> INFECTIONS | <input type="radio"/> ORGAN TRANSPLANT |

DO YOU HAVE ANY DISEASE OR CONDITION NOT MENTIONED ABOVE THAT WE SHOULD BE AWARE OF?

HAVE YOU OR ANY FAMILY MEMBER HAD A REACTION TO ANESTHESIA? Y N

LIST ALL OPERATIONS OR PROCEDURES YOU HAVE HAD:
