ADAM J. RUBINSTEIN, MD, PA

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Health Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient:			
DOB	Age	Marital Status	Weight lbs
What surgery are you considering?			Height ft in

DO YOU NOW OR HAVE YOU EVER HAD…….. (You must circle an answer for each individual item)

Heart Trouble	Yes	No	Glaucoma or Eye Problems	Yes	No
Heart Attack	Yes	No	Visual Disturbances	Yes	No
Heart Pain	Yes	No	Wear Glasses/Contacts	Yes	No
Palpitation or Irregular Pulse	Yes	No	Other Eye Problems	Yes	No
Extra Heart Beats	Yes	No	Hepatitis (A, B, or C)	Yes	No
Stroke	Yes	No	HIV, AIDS	Yes	No
Hypertension	Yes	No	Gallstones or Gallbladder Trouble	Yes	No
Blood Pressure Abnormalities	Yes	No	Cirrhosis of the Liver	Yes	No
Abnormal EKG	Yes	No	Alcoholism or Drug Dependency	Yes	No
Rheumatic Fever	Yes	No	Esophageal Varices	Yes	No
Heart Failure	Yes	No	Frequent Indigestion	Yes	No
Digitalis Treatment	Yes	No	Ulcers	Yes	No
Shortness of Breath	Yes	No	Gastritis	Yes	No
Chest Pain	Yes	No	Colitis	Yes	No
Asthma	Yes	No	Problem Constipation	Yes	No
Bronchitis	Yes	No	Vomiting Blood	Yes	No
Pneumonia	Yes	No	Tarry or Bloody Bowel Movements	Yes	No
Tuberculosis	Yes	No	Hemorrhoids	Yes	No
Smokers Cough	Yes	No	Goiter or Thyroid Disorders	Yes	No
Emphysema	Yes	No	Diabetes	Yes	No
Coughing or Spitting of Blood	Yes	No	Skin Disorders	Yes	No
Hay Fever	Yes	No	Arthritis	Yes	No
Major Allergies	Yes	No	Fracture of Neck or Spine	Yes	No
Palsy or Paralysis	Yes	No	Bleeding Tendency or Disorder	Yes	No
Nervous Breakdown	Yes	No	DVT (Deep Vein Thrombosis), Blood Clots	Yes	No
Nervous Disorder	Yes	No	Airway Obstruction (Nasal)	Yes	No
Insomnia	Yes	No	Breast Cysts, Tumors, Abscesses	Yes	No
Drug Habit	Yes	No	Nipple Discharge (Apart from Normal Lactation)	Yes	No
Self-Destructive Tendencies	Yes	No	Kidney Disorder	Yes	No
Psychiatric Hospitalization or Care	Yes	No	Blood Transfusion	Yes	No
Thyroid Problems	Yes	No	Seizures or convulsions or fainting spells	Yes	No
Kidney or Renal Disease	Yes	No	Black outs	Yes	No
Heart murmur	Yes	No	Dentures, bridges, capped teeth or crowns	Yes	No
Piercing other than the ears	Yes	No	Loose teeth	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No	Cosmetic bonding to teeth	Yes	No
Missed or irregular last menstrual period	Yes	No	Any family members with bleeding problems	Yes	No
Family history of cancer, heart trouble, stroke	Yes	No	Any family members with anesthesia problems	Yes	No

1. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Include over-the-counter medications.**

_____

_____

2. Do you have an allergic reaction to any medication? ❒ Yes ❒ No Which? _____

3. Do you react abnormally to any medication? ❒ Yes ❒ No Which? _____

4. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?

❒ Yes ❒ No If yes, when and where? _____

5. Have you ever been on cortisone or steroid treatment? ❒ Yes ❒ No When? _____

6. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?

❒ Yes ❒ No If so, how much? _____

7. Do you smoke? ❒ Yes ❒ No If so, how much? _____ For how long? _____

8. Are you pregnant? ❒ Yes ❒ No When was you last normal menstrual period? _____

9. How many pregnancies? _____ Births? _____ Breast Fed? ❒ Yes ❒ No How long? _____

CHILDREN (list names and ages/birthdays): _____

_____

10. When was your last physical exam? _____ By whom? _____

11. When was your last eye examination? _____ By whom? _____

12. When and where was your last chest x-ray? _____ EKG? _____

13. Who is your personal physician, if any? _____Please list all physicians presently caring for you.

_____

14. Have you ever been under psychiatric care? ❒ Yes ❒ No When? _____Why? _____

15. Have you had any recent blood work done? ❒ Yes ❒ No Where? _____

16. Is there anything else you think the doctor should know? _____

_____

17. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:

SURGICAL OPERATIONS (include where, when and why for each surgery): _____

_____

_____

HOSPITALIZATIONS (include where, when and why for each admission): _____

_____

_____

By signing below, I agreee that the above information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____