

**IRA PAPEL, M.D., F.A.C.S. ♦ THEDA KONTIS, M.D., F.A.C.S.**

Health Information as of \_\_\_\_\_ (enter today's date)  
 (Please Print Legibly & Fill In or Correct All Fields)

Name: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Feet \_\_\_\_\_ Inches Weight: \_\_\_\_\_ Lbs.

Current Physician(s): \_\_\_\_\_

List all Surgeries (Hospitalization and the Date of Occurrence):  
 \_\_\_\_\_  
 \_\_\_\_\_

Purpose of Visit: \_\_\_\_\_

**HPI (leave this area blank)**

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Aids / HIV	No	Yes	Epilepsy / Seizures	No	Yes	Kidney Problems	No	Yes
Arthritis	No	Yes	Facial Pain	No	Yes	Pneumonia	No	Yes
Asthma	No	Yes	Fever Blisters	No	Yes	Sinus Problems / Infections	No	Yes
Bronchitis	No	Yes	Goiter / Thyroid	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Hay Fever / Allergies	No	Yes	Tonsillitis	No	Yes
Depression	No	Yes	Headaches / Migraine	No	Yes	Tuberculosis	No	Yes
Diabetics	No	Yes	Heart Trouble	No	Yes	Ulcers	No	Yes
Dizziness / Vertigo	No	Yes	Hepatitis	No	Yes			
Ear Infection	No	Yes	High Blood Pressure	No	Yes			

Do you smoke?    No    Yes    If yes, how much? \_\_\_\_\_ Pack(s)/day    How long? \_\_\_\_\_ Years

Do you drink alcohol?    No    Yes    If yes, how much? \_\_\_\_\_    How often? \_\_\_\_\_

Do you use recreational drugs?    No    Yes    If yes, describe: \_\_\_\_\_

Do you have bleeding or bruising problems?    No    Yes    If yes, describe: \_\_\_\_\_

Do you have problems with scarring?    No    Yes    If yes, describe: \_\_\_\_\_

Do you have any history of problems with anesthesia?    No    Yes    If yes, describe: \_\_\_\_\_

List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.

List ALL drug and/or latex allergies.

**The above information is accurate and complete to the best of my knowledge.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_