CUMBERLAND PLASTIC SURGERY, P.C.

Name _____Date_____

Do you have any medication allergies? Yes No
If yes, please list _____

Are you taking any medications? Yes No
If yes, please list _____

Have you had <u>ANY SURGERIES</u>? (Major or minor surgeries, including mole removal, corrective eye surgery, etc.) Yes No
If yes, please list each surgery and year it occurred: _____
_____

Have you ever been diagnosed with any of the following illnesses? (Please circle yes or no)

Arthritis/Gout	Yes	No	AIDS/HIV	Yes	No
High Blood Pressure	Yes	No	Tuberculosis	Yes	No
Cancer	Yes	No	Kidney Disease	Yes	No
Diabetes	Yes	No	Frequent Kidney Problems	Yes	No
Epilepsy	Yes	No	Leukemia	Yes	No
Bleeding Disorder	Yes	No	GI Disorder	Yes	No
Pulmonary Disease	Yes	No	Congenital Abnormalities	Yes	No
Stroke	Yes	No	Heart Disease	Yes	No
Mental Disorder	Yes	No	Depression/Anxiety	Yes	No

If you answered yes to any of the above illnesses, please explain: _____

Are you using any form of birth control? Yes No
If yes, please list _____

How many times have you been pregnant? _____ How many children have you had? _____ Have you gone through menopause? _____

Have any of the above illnesses been diagnosed in:

Mothers Health History	Yes	No	if yes, please list _____
Fathers Health History	Yes	No	if yes, please list _____
Brother/Sister	Yes	No	if yes, please list _____

Mother:	Living	Deceased	Cause of Death _____
Father:	Living	Deceased	Cause of Death _____
Brother	Living	Deceased	Cause of Death _____
Sister	Living	Deceased	Cause of Death _____

Do you exercise? Yes No how many times a week? _____

Do you smoke? Yes No if yes, how much? _____

Do you drink? Yes No if yes, how much? _____

Did a physician refer you to our office? YES NO
If yes, who? _____

Who is your primary care physician? _____

Do you see any other physician on a regular basis? _____
If you answered yes, for what reason _____

Please list any problem or concern that we may need to be aware of _____
_____

Do you have a living will or a power of attorney? Yes No
Name: _____
Relationship to Patient: _____

Do you have any religious beliefs that we should be aware of? Yes No
If you answered yes, please explain _____

I, _____ hereby authorize Dr. John David Rosdeutscher and his staff to examine and perform diagnostic procedures and provide other care necessary to diagnose and/or treat my condition. I understand any pictures taken if they do not reveal my identity may be used for advertising, or medical display. I understand that unless submitted in writing, this office may leave messages on my answering machine or voice mail at the numbers I have given them.

Signature of Patient or Responsible Party _____
Date _____

****PLEASE MAKE SURE YOU FULLY ANSWERED ALL QUESTIONS ****

Thank you for your cooperation.