

Contemporary Cosmetic Surgery, Inc.
BRYAN J. MICHELOW, M.D.
Health History Completed by Patient

Patient Name:

Date:

Your E-mail Address:

How did you hear about Dr Michelow? - Referred by (Person's Name): _____

Doctor referral / Family member / Friend / Internet / Dr's Web Site / Newspaper Ad / Yellow Pages

Name of your Family Physician: _____ **Phone Number (if known):** (.....)

Your Occupation: _____

Reason for your visit:

Please mark all that apply:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Previous Heart Attack	<input type="checkbox"/> Asthma	<input type="checkbox"/> Persistent Cough
<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Other Bowel Disease	<input type="checkbox"/> Urinary Problems	<input type="checkbox"/> Headaches
<input type="checkbox"/> Sugar Diabetes	<input type="checkbox"/> Thyroid Replacement	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Nose Bleeds
<input type="checkbox"/> Joint Problems	<input type="checkbox"/> Other:		
<input type="checkbox"/> None of the above.			

Do you take any of these:

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Plavix	<input type="checkbox"/> Coumadin
<input type="checkbox"/> Herbal Meds	<input type="checkbox"/> Retin-A	<input type="checkbox"/> None of these

Other Medications:

Do you Smoke: No Less than 1 pack/day More than 1 pack/day

Alcohol Intake: None Occasional Daily

Please explain any problems marked above:

Allergies:

No Known Drug Allergies	
Other:	

Medications (Name & Dose):

Prior Surgeries (Date & Description):

Appendectomy / Tonsilectomy & Adenoids / Gall bladder Removed / Hysterectomy & Ovaries

Social: Married / Never Married / Widowed / Divorced (please circle one)

Height: _____ **Weight:** _____
Diet: Regular Other: _____ **Exercise Program:** _____

In your Family: Diabetes: Y/N/Unknown – Who: _____
Heart Attack: Y/N/Unknown – Who: _____
Cancer : Y/N/Unknown – Who: _____

Other Health Information: