

*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:**

<b>No Known Drug Allergies</b>	
<b>Other:</b>	

**Medications (Name & Dose):**

**Prior Surgeries (Date & Description):**

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


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

<b>Height:</b>	<b>Weight:</b>
<b>Diet:</b> Regular Other:	<b>Exercise Program:</b>

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

**Other Health Information:**