D.J. VERRET, MD, PA

972.608.0100

6545 Preston Road, Suite 200, Plano, TX 75024

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

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

Patient:			
DOB			Weight lbs
What are you seeing the doctor for?			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	
Palpitation or Irregular Pulse	Yes	No		Error in Refraction	Yes	No	
Extra Heart Beats	Yes	No		Other Eye Problems	Yes	No	
Stroke	Yes	No		Hepatitis	Yes	No	
Hypertension	Yes	No		Yellow Jaundice	Yes	No	
Blood Pressure Abnormalities	Yes	No		Gallstones or Gallbladder Trouble	Yes	No	
Abnormal EKG	Yes	No		Cirrhosis of the Liver	Yes	No	
Rheumatic Fever	Yes	No		Alcoholism or Drug Dependency	Yes	No	
Dropsy or Heart Failure	Yes	No		Esophageal Varices	Yes	No	
Digitalis Treatment	Yes	No		Frequent Indigestion	Yes	No	
Shortness of Breath	Yes	No		Ulcers	Yes	No	
Chest Pain	Yes	No		Gastritis	Yes	No	
Asthma	Yes	No		Colitis	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		Abnormal Bleeding after Tooth Extraction	Yes	No	
Nervous Disorder	Yes	No		Airway Obstruction (Nasal)	Yes	No	
Insomnia	Yes	No		Neurologic Disorder	Yes	No	
Drug Habit	Yes	No		Kidney Disorder	Yes	No	
Self-Destructive Tendencies	Yes	No		Blood Transfusion	Yes	No	
Psychiatric Hospitalization or Care	Yes	No		Seizures or convulsions or fainting spells	Yes	No	
Thyroid Problems	Yes	No		Black outs	Yes	No	
Kidney or Renal Disease	Yes	No		Dentures, bridges, capped teeth or crowns	Yes	No	
Heart murmur	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					

1. **Please list all present medications and doseages**, 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. Are you currently taking or have you taken Accutane or its generic form tretinoin in the last 6 months? ❒ Yes ❒ No

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

❒ Yes ❒ No If so, how much? _____

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

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

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 agree that the above information is complete and accurate to the best of my knowledge.

_____ _____

Patient/Parent/Guardian Signature Date