

PAUL VITENAS JR., M.D.

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

Patient's Name _____
First Middle Last

Age _____ Birthdate _____ Height _____ Weight _____ Gender Female Male
Bra _____ Pant _____

Purpose of Visit: _____

Whom may we thank for referring you? _____

Drug or Latex Allergies: (please indicate if none)

Do you smoke? No Yes

How many packs a day? _____

Medications: (include all Prescriptive, Over-The-Counter, Vitamins and Herbal medications taken regularly)

Previous Surgeries with Dates: (Including cosmetic)

Health Problems Past & Present: (mark all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Lung/Breathing Problems | <input type="checkbox"/> Bleeding/Clotting Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Psychiatric / Depression | |

Other: _____

Please explain all positive responses: _____

Primary Physician _____ Phone _____
First and Last Name

Date of Last Physical: _____

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

Signature _____ **Date** _____

Your electronic signature on this form is your legal signature signifying that you understand what has been presented to/discussed with you and you have given your informed consent to the policies.