Alexandra Dresel, M.D. FACS

Today's Date____________

Name: ____Age:____Birthdate:__/__/____

Reason for today's visit: ____

Name of your Primary Care Doctor/Gyn: _______________________________________

Name of the doctor that referred you here :____________________________________

Do you have a Cardiologist?:____

Do you have a Gastroenterologist?____

Please list any other doctors to send your results/records:

1. ______________________________ 5. ______________________________
2. ______________________________ 6. ______________________________
3. ______________________________ 7. ______________________________
4. ______________________________ 8. ______________________________

List any surgeries you have had and the approximate dates:

1. ______________________________ 5. ______________________________
2. ______________________________ 6. ______________________________
3. ______________________________ 7. ______________________________
4. ______________________________ 8. ______________________________

List any medical conditions you have been treated for (i.e. High blood pressure, Diabetes, Asthma, etc..)

1. ______________________________ 5. ______________________________
2. ______________________________ 6. ______________________________
3. ______________________________ 7. ______________________________
4. ______________________________ 8. ______________________________

List any medical problems that run in your family

1. ______________________ 5. ______________________
2. ______________________ 6. ______________________
3. ______________________ 7. ______________________
4. ______________________ 8. ______________________

***Do you take Aspirin, Coumadin, or Plavix?________________
***Do you take Phentermine? ______________________________

Please list all current medications:

1. ______________________ 5. ______________________
2. ______________________ 6. ______________________
3. ______________________ 7. ______________________
4. ______________________ 8. ______________________

Are you allergic to any medications? ________________________________

Do you have Sleep Apnea? ____

Do you smoke cigarettes or a pipe? _______**How much?** ______________

If you quit, when did you quit? __________________________________

Do you drink alcohol? ______________**How much?**________________

What is your occupation? ____

Patient signature:____________________________ **Date**_____________

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