

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. _____ |

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. _____ |

What is your Pharmacy phone number? _____

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** _____
