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_____