Alexandra Dresel, M.D. FACS

Today's Date_____

Name:_____**Age:**_____**Birthdate:**_____

Reason for Today's Visit: _____
Name of Your Primary Care Doctor_____
Name of The Doctor That Referred You Here: _____

Medical History

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 (e.g. High Blood Pressure, Diabetes, Asthma, etc)

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

List Your Current Medications

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

Are You allergic to any medications? Yes No

If Yes, Which One(s)_____

Do You Take Asprin? Yes No
Do You Take Coumadin? Yes No
Do You Take Plavix? Yes No

Have You Ever Had A Blood Transfusion? Yes No

Have You Ever Had A Blood Clot? Yes No

Have You Ever Had A Colonoscopy? Yes No
When? _____
Have You Ever Had A Stress Test? Yes No
When? _____

Do You Ever Have Shortness Of Breath When Resting? Yes No

Do You Have Sleep Apnea? Yes No

Do You Ever Have Chest Pain At Rest? Yes No

Do You Ever Have Chest Pain With Activity? Yes No

Women Only

Age Of Onset Of Menses: _____**Date of Menopause**_____

How Many Children Do You Have? _____ **Name of Gynecologist:** _____

Family History

List any Medical Problems That Run In Your Family

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

Social History

Do You Smoke Cigarettes Or A Pipe? **Yes** **No**
How Much? _____

If You Quit, When Did You Quit? _____

Do You Drink Alcohol? **Yes** **No**
How Much? _____

What is Your Occupation? _____

Do You Exercise On A Regular Basis? **Yes** **No**
What Type? _____
How Often Do You Exercise? _____

Patient Signature: _____ **Date:** _____