FADY A. SINNO, M.D. 410-884-4200

Health Information as of _______________ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name: ______________________ Reason for visit: ______________________

Age: __________ Height: _____ Feet _____ Inches Weight: _____ Lbs. (BMI office use only)

Primary Care Physician(s): ______________________ Phone: ______________

Do you have or have you had any of the following: (circle for each)

Aids / HIV	No	Yes	Fever Blisters	No	Yes	Shortness of breath	No	Yes
Asthma	No	Yes	Heart Trouble	No	Yes	Sleep Apnea	No	Yes
Cancer	No	Yes	Hepatitis/ Liver Disease	No	Yes	Stroke	No	Yes
Chest Pain	No	Yes	High Blood Pressure	No	Yes	Swelling of Ankles	No	Yes
Dizziness/ Vertigo	No	Yes	Jaundice	No	Yes	Thyroid/ Goiter	No	Yes
Diabetes	No	Yes	Kidney Problems	No	Yes	Prolonged Bleeding	No	Yes

Do you smoke? No Yes How much? _____ Pack(s)/day How long? _____ Years_____

Do you drink alcohol? No Yes How much? __________ How often? __________

Do you use recreational drugs? No Yes If yes, describe: __________

Do you have bleeding or bruising problems? No Yes If yes, describe: __________

Do you have problems with scarring? No Yes If yes, describe: __________

Do you have a history of problems w/ anesthesia? No Yes If yes, describe: __________

Do you take or have ever taken steroids No Yes If yes, describe:

Do you take: (circle for each)

Blood Thinners	No	Yes	High Blood Pressure Meds	No	Yes	Aspirin	No	Yes
Heart Medication	No	Yes	Diuretics (water pills)	No	Yes	If yes, frequency		

List all **medications** you are presently taking (including vitamins & herbal supplements). Please include name, dosage and frequency.

List ALL drug and/or latex **allergies**.

List all Surgeries (Hospitalization and/or Accidents):

List any Serious Illnesses and/or Accidents:

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

Patient Signature ______________________ **Date** __________

Physician Signature ______________________ **Date** __________