



1. Please specifically give the reason for your visit:

If your reason involves an injury or injuries, please describe the nature and give dates:

2. Please list all drug-related allergies or intolerances (or indicate none).

3. Are you under a doctor's care? YES NO

NAME OF PHYSICIAN	PHONE
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ADDRESS	[CITY/STATE/ZIP]
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Date of last complete physical examination?

4. Have you ever seen an allergist? YES NO

NAME OF PHYSICIAN	PHONE
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ADDRESS	[CITY/STATE/ZIP]
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5. List all medications you are currently taking, along with the dosage and frequency:

(including over the counter medicines, aspirin or medicines containing aspirin, birth control pills, diet pills, Vitamin E, or herbal preparations)

6. List all previous operations or major illnesses and all hospitalizations you have had, along with dates.

7. Have you had a Botox Injection? YES NO

WHEN	WHERE
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FAMILY HISTORY

Alcoholism	YES <input type="checkbox"/> NO <input type="checkbox"/>	High Blood Pressure	YES <input type="checkbox"/> NO <input type="checkbox"/>	Diabetes	YES <input type="checkbox"/> NO <input type="checkbox"/>
Family Estrangements	YES <input type="checkbox"/> NO <input type="checkbox"/>	Cancer	YES <input type="checkbox"/> NO <input type="checkbox"/>	Strokes	YES <input type="checkbox"/> NO <input type="checkbox"/>
Allergies	YES <input type="checkbox"/> NO <input type="checkbox"/>	Nervous Breakdown	YES <input type="checkbox"/> NO <input type="checkbox"/>	Epilepsy	YES <input type="checkbox"/> NO <input type="checkbox"/>
Heart Attacks	YES <input type="checkbox"/> NO <input type="checkbox"/>	Congenital Defects	YES <input type="checkbox"/> NO <input type="checkbox"/>	Suicide	YES <input type="checkbox"/> NO <input type="checkbox"/>
Bleeding Tendencies	YES <input type="checkbox"/> NO <input type="checkbox"/>	Stomach Problems	YES <input type="checkbox"/> NO <input type="checkbox"/>		

HEIGHT	WEIGHT
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This information is correct and complete to the best of my knowledge, and I give my permission for you to contact and communicate with my physicians and insurance company.

NAME	DATE
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Thank You for Choosing FPSA

GENERAL PATIENT HISTORY

Do you have (or have you had) any of the following?

PAST			PRESENT	
YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	Nasal Allergy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Discharge	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing Through Nose	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Do You Use a CPAP	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Trouble	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	+HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever smoked? YES NO

Do you currently use tobacco? YES NO

How many packs a day?

How many years?

Do you drink alcohol? YES NO

How many drinks per day?

Indicated if drugs or alcohol posed a dependency problem for you: DRUGS ALCOHOL

Have you had exposure to HIV through prior sexual history, surgery, transfusions or IV drug use? YES NO

Have you had a reaction to anesthetics? YES NO

Do you have a history of increased bleeding tendency? YES NO

Have you ever had a blood transfusion? YES NO

Have you ever been under the care of a psychiatrist? YES NO

Have you ever had a nervous breakdown? YES NO

Do you wear glasses? YES NO

Are your glasses just for reading? YES NO

Do you wear contacts? YES NO

Do you have a history of bad scarring? If yes, where? YES NO