Patient Name: _____ Account #: _____

CURRENT MEDICAL INFORMATION

What type of problem will you be consulting Dr. Roland for today? _____

_____

_____

How long has the problem existed? _____

Please state the location of the problem _____

Is there anything else you would like to tell us about why you are here today? _____

_____

_____

ALLERGIES AND MEDICATIONS

Are you allergic to any medications? Yes / No

If yes, please list: _____

_____

Please list any medications you are currently taking, including birth control, supplements and vitamins:

Medication, Dosage & Frequency: _____

Medication, Dosage & Frequency: _____

Medication, Dosage & Frequency: _____

Medication, Dosage & Frequency: _____

Medication, Dosage & Frequency: _____

Medication, Dosage & Frequency: _____

PREVIOUS HOSPITAL ADMISSIONS

Procedure	Year

PLEASE CIRCLE YOUR SMOKING STATUS

Current Smoker: every day / some days Former Smoker Never Smoker

PLEASE CIRCLE THE ITEMS YOU ARE INTERESTED IN RECEIVING INFORMATION ABOUT

Botox
Flushing
Brown spots
Removal of varicose & spider veins
Rejuvapen
Cosmetic Fillers – Radiesse, Juvederm
Esthetics Skin Care products
Blue Light Therapy for acne and sun-damage
Treatment of wrinkles & aging skin
Mailing list / Newsletters

PLEASE CIRCLE ANY OF THE FOLLOWING MEDICAL CONDITIONS THAT YOU CURRENTLY HAVE

Anxiety
Arthritis
Asthma
Arterial Fibrillation
BPH
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV / AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other_____
None
Allergy to Adhesives
Allergy to Latex
Allergy To Lidocaine
Artificial Heart Valve
Artificial Joints (in the last 2 years)
Blood Thinners
Defibrillator
Increase Heartbeat with Epi
Pacemaker
Pregnant or Planning Pregnancy
Premedication Before Procedures
Upset Stomach w/ Antibiotics
Yeast Infection w/ Antibiotics

INTEGUMENTARY

Acne
Actinic Keratoses
Basal Cell Carcinoma
Blistering Sunburns
Changing Mole
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Carcinoma
Family History of Melanoma
if yes, whom_____

NEUROPSYCHIATRIC

Depression
Seizures
Sore Throat
Headaches
Blurry Vision

HEMATOLOGY

Problems with Bleeding, Healing or Scarring
A Reaction or Allergies to Local Anesthetics
Have you been tested for AIDS, results _____
Have you been tested for Hepatitis, results _____

CARDIO-RESPIRATORY

History of TB or Exposure to TB
Chest Pain
Shortness of Breath
High Blood Pressure
Heart Attacks
Asthma
Wheezing
Night Sweats
Varicose Veins
Unintentional Weight Loss
Cough

ENDOCRINE

Diabetes
Fever or Chills
Immunosuppression
Sensitivity to Cold
Thyroid Disease

NEUROMUSCULAR

Pain
Weakness in Muscles
Arthritis
Neck Stiffness

GASTRO-INTESTIONAL

Abdominal Pain
Gallbladder
Bloody Stool
Bloody Urine