ROBERT J. CHIU, M.D.

TODAY'S COSMETIC SURGERY & LASER CENTER, P.C.

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/food-related allergies or intolerances (or indicate none): ____________________

3. Are you under a dermatologist's care? _____ No _____ Yes NAME of physician: ____________________

PHONE: ____________________ ADDRESS: ____________________

Date of last complete physical examination ____________________

4. Have you ever seen an allergist? _____ No _____ Yes NAME of allergist: ____________________

PHONE: ____________________ ADDRESS: ____________________

5. Do you have (or have you had) any of the following ailments? **Please Circle Answer or Fill in Blank**

PAST YES	PAST NO		PRESENTLY YES	PRESENTLY NO	PAST YES	PAST NO		PRESENTLY YES	PRESENTLY NO
☐	☐	Heart trouble	☐	☐	☐	☐	Nasal allergy	☐	☐
☐	☐	Mitral valve prolapse	☐	☐	☐	☐	Post-Nasal discharge	☐	☐
☐	☐	Diabetes	☐	☐	☐	☐	Sinus infections	☐	☐
☐	☐	Ulcers	☐	☐	☐	☐	Nose bleeds	☐	☐
☐	☐	Anemia	☐	☐	☐	☐	Headaches	☐	☐
☐	☐	Asthma	☐	☐	☐	☐	Hepatitis C/B/A	☐	☐
☐	☐	Pulmonary trouble	☐	☐	☐	☐	Dizziness or Vertigo	☐	☐
☐	☐	High blood pressure	☐	☐	☐	☐	Difficulty breathing through nose	☐	☐
☐	☐	+ HIV/AIDS	☐	☐					

Have you ever smoked? Yes No

Do you currently use tobacco? Yes No

How many packs per day______

How long? ________ years

Do you drink alcohol? Yes No

0-1 drinks per day __________

2-3 drinks per day __________

4+ drinks per day __________

Indicate if drugs or alcohol ever posed a dependency problem for you:

_____ Drugs ______ Alcohol

6. List **ALL** medications you are currently taking (including over the counter medicines, aspirin or aspirin containing medicines, birth control pills, diet pills, Vitamin E, or herbal preparations), along with the dosage and frequency:

____

7. List **ALL** previous procedures,operations or major illnesses you have had, along with approximate dates: ____________________

____

8.

	YES	NO
Have you had exposure to HIV or HepC from surgery, sexual history, transfusions or IV drug use?	☐	☐
Have you had a reaction to anesthetics?	☐	☐
Do you have a history of increased bleeding tendency?	☐	☐
Have you ever had a blood transfusion?	☐	☐
Have you ever been under the care of a psychiatrist?	☐	☐
Have you ever had a nervous breakdown?	☐	☐
Do you wear glasses?	☐	☐
Are your glasses just for reading?	☐	☐
Do you wear contacts?	☐	☐
Do you have a history of bad scarring?	☐	☐

If yes, where? ____________________

9. Family History

	YES	NO		YES	NO
Alcoholism	☐	☐	Family Estrangements	☐	☐
Allergies	☐	☐	Heart Attacks	☐	☐
Bleeding Tendencies	☐	☐	High Blood Pressure	☐	☐
Cancer	☐	☐	Nervous Breakdown	☐	☐
Congenital Defects	☐	☐	Stomach Problems	☐	☐
Diabetes	☐	☐	Strokes	☐	☐
Epilepsy	☐	☐	Suicide	☐	☐

HEIGHT:_______ WEIGHT:_______

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.

(Signature) ____________________

(Date) ______/______/______

PT. ID #

PT. NAME:

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