JOSEPH J. FATA, M.D.

OFFICE INFORMATION

Last Name: _____ First Name: _____ M.I.: _____

Street Address: _____

City: _____ State: _____ Zip: _____

e-mail Address: _____ Cell Phone: _____

Date of Birth: _____ Sex: M F

Pharmacy:

Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Primary Insurance (Cosmetic surgery patients do not need to fill out):

Relationship of policyholder to patient: Self Spouse Parent

Insurance Co: _____ Group #: _____ Policy #: _____

Address: _____ City: _____. State: _____ Zip: _____

JOSEPH J. FATA, M.D.
MEDICAL HISTORY

Last Name: _____ First: _____ Middle: _____

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

How were you referred to our office? Friend or Family _____ Doctor _____

Internet (Please identify any referrals from a specific website) _____

What is the reason for your visit? _____

List Drug Allergies: _____

Current medications with doses (including non-prescription drugs such as aspirin): _____

_____

Do you or have you ever had: (Circle and give date of onset)

Heart Disease	No	Yes	_____	Psychiatric illness	No	Yes	_____
Heart Attack	No	Yes	_____	Neurologic disease	No	Yes	_____
Lung disease	No	Yes	_____	Bleeding tendency	No	Yes	_____
Asthma	No	Yes	_____	Bruising tendency	No	Yes	_____
High blood pressure	No	Yes	_____	Radiation therapy	No	Yes	_____
Stroke	No	Yes	_____	Rheumatic fever	No	Yes	_____
Diabetes	No	Yes	_____	Ulcers	No	Yes	_____
Hepatitis	No	Yes	_____	Cancer	No	Yes	_____
Kidney disease	No	Yes	_____	Breast disease	No	Yes	_____
Thyroid disease	No	Yes	_____	Depression	No	Yes	_____
Tuberculosis	No	Yes	_____	Slow healing	No	Yes	_____

Do you smoke? No ____ Yes ____ How much? _____
Do you drink alcohol/beer? No ____ Yes ____ How much? _____
Are you at risk for HIV (AIDS)? No ____ Yes ____

Previous surgery (include dates): _____

_____

_____

Family History of Illnesses: _____

Do you know of a blood relative who has had a bleeding disorder or an adverse reaction to anesthesia?

No ____ Yes ____ (If yes, give details)_____

_____

EMERGENCYCONTACT: _____
Name Relation Daytime Phone #