



John L. LeRoy, M.D., F.A.C.S., P.C.

HEALTH INFORMATION

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Who referred you to this office? \_\_\_\_\_

May we send them a "Thank You" note? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ (Please Initial)

What is your reason for today's visit? \_\_\_\_\_

Have you ever seen a Plastic Surgeon before? \_\_\_\_\_

Are you now under medical/therapeutic treatment? \_\_\_\_\_

If so, for what condition? \_\_\_\_\_

Please list your doctor's name and phone number: \_\_\_\_\_

List any medications you are taking (including aspirin): \_\_\_\_\_

List any accidents or operations (dates & descriptions): \_\_\_\_\_

Please circle any of the symptoms or physical problems listed below that you are currently experiencing or have experienced.

Table with 4 columns: Allergies, Stroke, Kidney Stones, Diabetes, Arthritis, Respiratory/Lungs, Pregnant, Nausea/Vomiting, Headaches, Chest Pain, Breast Lump, Indigestion, Dizziness, Blood Pressure, Vision/Contacts, Fatigue, Seizures, Heart, Cataract, Depression, Numbness, Circulation, Hearing, Other