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.

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