Alexandra Dresel, M.D. FACS

Today's Date___________________

Name:_________________________________Age:_____Birthdate:______________

Reason for Today's Visit: ____
Name of Your Primary Care Doctor____
Name of The Doctor That Referred You Here: ____________________________

Medical History

List Any Surgeries You Have Had and The Approximate Dates

1.______________________________ **5.**______________________________
2.______________________________ **6.**______________________________
3.______________________________ **7.**______________________________
4.______________________________ **8.**______________________________

List Any Medical Conditions You Have Been Treated For
(e.g. High Blood Pressure, Diabetes, Asthma, etc)

1.______________________________ **5.**______________________________
2.______________________________ **6.**______________________________
3.______________________________ **7.**______________________________
4.______________________________ **8.**______________________________

List Your Current Medications

1.______________________________ **5.**______________________________
2.______________________________ **6.**______________________________
3.______________________________ **7.**______________________________
4.______________________________ **8.**______________________________

Are You allergic to any medications? **Yes No**

If Yes, Which One(s)____

Do You Take Asprin? **Yes No**
Do You Take Coumadin? **Yes No**
Do You Take Plavix? **Yes No**

Have You Ever Had A Blood Transfusion? **Yes No**

Have You Ever Had A Blood Clot? **Yes No**

Have You Ever Had A Colonoscopy? **Yes No**
When? ___________________
Have You Ever Had A Stress Test? **Yes No**
When? ___________________

Do You Ever Have Shortness Of Breath When Resting? **Yes No**

Do You Have Sleep Apnea? **Yes No**

Do You Ever Have Chest Pain At Rest? **Yes No**

Do You Ever Have Chest Pain With Activity? **Yes No**

Women Only

Age Of Onset Of Menses: _____________________Date of Menopause_________________________

How Many Children Do You Have? _______ Name of Gynecologist: _________________________

Family History

List any Medical Problems That Run In Your Family

1.__________________________________ **5.__________________________________**
2.__________________________________ **6.__________________________________**
3.__________________________________ **7.__________________________________**
4.__________________________________ **8.__________________________________**

Social History

Do You Smoke Cigarettes Or A Pipe? **Yes** **No**
How Much? ______________________________

If You Quit, When Did You Quit? ______________________________

Do You Drink Alcohol? **Yes** **No**
How Much? ______________________________

What is Your Occupation? ______________________________

Do You Exercise On A Regular Basis? **Yes** **No**
What Type? ______________________________
How Often Do You Exercise? ______________________________

Patient Signature: ______________________ **Date:** ______________

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