ANYA KISHINEVSKY, MD (203) 388-9919

Health Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

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

Name: _____ Reason for Visit: _____

Age: _____ Height: _____ Feet _____ Inches Weight: _____ Lbs.

Current Physician(s): _____

List all Surgeries (Hospitalization and the Date of Occurrence):

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

AIDS / HIV	No	Yes	Epilepsy / Seizures	No	Yes	Kidney Problems	No	Yes
Arthritis	No	Yes	Facial Pain	No	Yes	Pneumonia	No	Yes
Asthma	No	Yes	Fever Blisters	No	Yes	Sinus Problems / Infections	No	Yes
Bronchitis	No	Yes	Goiter / Thyroid	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Hay Fever / Allergies	No	Yes	Tonsillitis	No	Yes
Depression	No	Yes	Headaches / Migraine	No	Yes	Tuberculosis	No	Yes
Diabetes	No	Yes	Heart Trouble	No	Yes	Ulcers	No	Yes
Dizziness / Vertigo	No	Yes	Hepatitis	No	Yes			
Ear Infection	No	Yes	High Blood Pressure	No	Yes			

Do you smoke? No Yes If yes, how much? _____ Pack(s)/day How long? _____ Years

Do you drink alcohol? No Yes If yes, how much? _____ How often? _____

Do you use recreational drugs? No Yes If yes, describe: _____

Do you have bleeding or bruising problems? No Yes If yes, describe: _____

Do you have problems with scarring? No Yes If yes, describe: _____

Do you have any history of problems with anesthesia? No Yes If yes, describe: _____

Preferred Pharmacy:

List ALL drug and/or latex allergies.

The above information is accurate and complete to the best of my knowledge.

Signature _____ **Date** _____