Name:						Date:			
	DATIEN	IT CONE	IDENTIAL	MEDICAL I	JICTO	DV FOR			
	PATIEN	VI CONT		Leary, M.D.	11310	KT FUK	<u>VI</u>		
Please answer ALL quest	ions. If you do not	understar			answ	r write "?	" in the	snace lise the ha	ck of thi
form if additional space i				OH OF KHOW LIK	. a115	ii, write:	iii tile	space. Ose the ba	ick of thi
Nature of Complaints									
General Health									
Height:	Weight	t:							
Do you smoke? Y/N/Qui	it. If yes, how m	any packs,	/day/how lo	ng?		If you o	uit, wh	at year?	
Alcoholic Beverages/Day	/:		Coffees/I	Day:			Tea	as/Day:	
Alcoholic Beverages/Day Do you have any medica	tion allergies? Y/N	I. If yes, ple	ease list:	,					
What types of allergic re	action did you hav	re?							
Past Medical History-									
Asthma Y/N	COPD/Emphyse	ma Y/N						Urinary Tract Infe	ection Y
Bleeding Disorder Y/N			High Choles		Strok			Other:	
Cancer Y/N	Heart Disease	Y/N	Kidney Dise	ase Y/N	Thyro	id Disorde	Y/N		
Family History-Do any	of your family mer	mbers have	e or had any	major illnesses	? If no	ne, please	write no	one.	
Family Member:				Illness/Con	dition:				
Surgical History- If non	e. please write no	ne. Use the	hack of this	form if addition	nal en	re is need	ed		
	e, please write no			form if addition	onal sp			nation (840 MD)	
Surgical History- If non Name of Surgery:	e, please write no		e back of this f Surgeon:	form if addition	onal sp			ation: (MO/YR)	
	e, please write no				onal sp			ration: (MO/YR)	
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Name of Surgery:		Name of	f Surgeon:	- \		Date	of Oper		
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Name of Surgery: Current Medications-		Name of	f Surgeon:	- \		Date of	of Oper		
Name of Surgery: Current Medications-		Name of	f Surgeon:	of this form if a		Date of	of Oper	d.	
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Name of Surgery: Current Medications-		Name of	f Surgeon:	of this form if a		Date of	of Oper	d.	
Name of Surgery: Current Medications- Name of Medication:	lf none, please wri	Name of	Se the back	of this form if a	ddition	Date of	needed	d. .g. 1/day):	
Current Medications- Name of Medication:	lf none, please wri	Name of	Se the back	of this form if a	ddition	Date of	needed	d.	
Current Medications- Name of Medication: Do you take aspirin? Y/N f yes, please list:	lf none, please wri	Name of	Se the back	of this form if a	ddition	Date of	needed	d. .g. 1/day):	
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Current Medications- Name of Medication: Do you take aspirin? Y/N f yes, please list: Do you have or have y Abnormal bleeding or a	If none, please wri Do you t	Name of	se the back Medication Py/N	of this form if a (e.g. 10 mg): Do you ta	ddition	Date of all space is Frequence other type	needed	d. .g. 1/day):	Y/N Y/N
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