

BEVERLY HILLS PROFILES

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www.beverlyhillsprofiles.com

1. Please specifically give the reason for your visit: _____

2. Please list all drug-related allergies or intolerances (or indicate none): _____

3. Are you under a doctor's care? _____ No _____ Yes NAME of physician: _____

PHONE: _____ ADDRESS: _____

Date of last complete physical examination _____

4. Do you have (or have you had) any of the following ailments?

PAST		PRESENTLY		PAST		PRESENTLY		PLEASE ANSWER	
YES	NO	YES	NO	YES	NO	YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you currently smoke?	Yes No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How many packs per day?	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever smoked?	Yes No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How long?	_____ Years
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol?	Yes No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	# drinks per day	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of drugs or alcohol dependency?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Drugs	_____ Alcohol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

5. List all medications you are currently taking (including over the counter medicines, aspirin or aspirin containing medicines, birth control pills, diet pills, Vitamin E, or herbal preparations), along with the dosage and frequency:

6. List all previous operations or major illnesses you have had, along with approximate dates: _____

	YES	NO
7. Have you had a reaction to anesthetics?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of increased bleeding tendency?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been under the care of a psychiatrist?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses or contacts?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of bad scarring?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, where? _____		

8. Family History		YES	NO		YES	NO	
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attacks	<input type="checkbox"/>	<input type="checkbox"/>		Anesthetic Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding Tendencies	<input type="checkbox"/>	<input type="checkbox"/>		Allergies	<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT: _____ WEIGHT: _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Strokes	<input type="checkbox"/>	<input type="checkbox"/>	
Myasthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>					

This information is correct and complete to the best of my knowledge, and I give my permission for you to contact and communicate with my physicians and insurance company.

(Signature) _____

Date _____