COMBS
PLASTIC SURGERY
& AESTHETICS
GREGORY L. COMBS, M.D. P.C.
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503-655-9727

PATIENT HEALTH ASSESSMENT

NAME: _____DOB: _____
Reason for Visit_____

Ht. ____ft ____in	Wt. _____lb	EKG if over 50 Y(date_____) N	Circle if you use: Caffeine Alcohol- _____/wk Cigarettes/Tobacco- _____/day Recreational drugs_____	Female: Pregnant Y N

List all **SURGERIES / MEDICAL CONDITIONS** with date of occurrence including snoring/sleep apnea.(use the back if needed)

_____
_____
_____

List all **ALLERGIES**: to include medication, food, or seasonal allergies

_____
_____
_____

List all **MEDICATIONS** or drugs you are now taking or have taken in the last month (including birth control pills, herbal supplements, vitamins, over-the-counter medications).

_____
_____
_____
_____

Family Medial History:

_____
_____
_____
_____

Do you have:	Y	N		Y	N
Latex sensitivity			Diabetes: Type I Type II		
Shortness of breath			Glaucoma		
Sleep Apnea- CPAP machine			Thyroid problems		
Heart palpitations			Bruising/bleeding		
Heart problems			Nausea from medications		
Stroke			Motion sickness		
High blood pressure			Seizures		
Fever blisters			Hiatal hernia/gastric reflux		
Asthma Wheezing Inhaler			Hepatitis: A B C		

Emergency Contact Name: _____Phone: _____

CONSENT FOR TRANSFER
In the event of an emergency or the necessity to be transported to a hospital facility, permission is given to Dr. Gregory L. Combs to arrange transfer by ambulance.

Patient Signature_____Date _____