# LORI G. POLACEK, M.D., INC.

Health Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

**Patient's Name** _____
First Middle Last

Age _____ Birthdate _____ Height _____ Weight _____ Gender ❒ Female ❒ Male

**Purpose of Visit:** _____

_____

**Previous Surgeries with Dates:** (Including cosmetic)

_____

_____

_____

**Health Problems Past & Present:** (mark all that apply)

❒ Diabetes ❒ High Blood Pressure ❒ Heart Problems
❒ Easy Bruising ❒ Lung/Breathing Problems ❒ Bleeding/Clotting Problems
❒ Cancer ❒ Psychiatric / Depression
❒ Other: _____

Please explain all positive responses: _____

_____

**Do you smoke?** ❒ No ❒ Yes, How many packs a day? _____

**Medications:** (include all Prescriptive, Over-The-Counter, Vitamins and Herbal medications taken regularly)

_____

_____

_____

**Drug or Latex Allergies:** (please indicate if none)

_____

_____

**Primary Physician** _____ Phone _____
First and Last Name

Date of Last Physical: _____

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

**Signature** _____ **Date** _____