ALASKA BREAST & COSMETIC CENTER

Health. Hope. Confidence.

NEW PATIENT HISTORY AND PHYSICAL

Please indicate reason for this office visit:_____

_____

Medications: (Please list strength) _____

_____

_____

Allergies to medications: _____

_____

Past Medical History:

☐ NONE / Unremarkable
☐ Asthma
☐ Chronic Obstructive Lung Disease
☐ Congestive Heart Failure
☐ Other _____
☐ Coronary Artery Disease
☐ Diabetes
☐ HIV/AIDS
☐ Hypertension
☐ Obstructive Sleep Apnea
☐ Seizure Disorder
☐ Thyroid Disease
☐ Tuberculosis

Past Surgical History/Hospitalization(s): (please list year and procedure)

Surgery	Procedure	Year

Past Medical History:

Current alcohol use: ☐ / ☐ # Drinks per day _____ # Drinks per week _____

Street drug intake: _____

Current # of cigarettes/day: _____ Past cigarette use (# of years) _____ # Interested in quitting ☐ / ☐

☐ Never smoked Year quit smoking: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Family History:

_____

_____

_____

Patient Signature: _____ **DOB:** _____ **Date:** _____