John M. McAvoy, M.D., F.A.C.S

Welcome to our office!

Please complete the following prior to you first visit. For the sake of privacy, many of our patients prefer to download this form and carry it with them to the office.

Name____
Last First Middle Mr. Mrs. Ms. Dr. Rev.

Preferred Name or nickname______________________

☐ Male ☐ Female ☐ Single ☐ Married ☐ Div ☐ Sep

Birthdate:____/____/____ Age:_____

Soc. Sec #_(last 4 digits)_________or

Driver's lic. #____________State__________Exp.______

Home Address ____

Home phone #_(_____)________Car or cell _________

E mail________________ Work phone________________

Preferred place & time to reach you _____________

Employer and Employer's Address ____

Referred by_________________Other members of you family in our practice (they will not have any knowledge you were here)____

Friend or neighbor not at your address _________________

Relationship_______________Phone________________________

Spouse or domestic partner:

Name______________________

Work phone______________Home Phone_______________

FAMILY HEALTH HISTORY

Mother's Age______or Age at death, cause________________

Father's Age_______or Age at death, cause________________

Health problems, Mother or Father, (include depression)____

Ages and Health of all siblings living or deceased____

Family medical problems: (please circle and list relatives and disease below:

	Relative
Congenital defects:	___________________________________
Allergies	___________________________________
Death during surgery	___________________________________
Lung disease	___________________________________
High Blood pressure	___________________________________
Breast cancer	___________________________________
Other Cancer (type)	___________________________________
Mental diseases, depression, suicide or attempts	___________________________________
Diabetes	___________________________________
Heart disease	___________________________________
Tuberculosis	___________________________________
Thyroid disease	___________________________________
Seizures	___________________________________
HIV, STD	___________________________________
Other	___________________________________

YOUR HEALTH HISTORY

Personal physician____

Address ____
Street City

____
State Phone

Date of:

Last physical exam______________ Mammogram___________

EKG____________ Chest or other X ray _________

menstrual period ________________(YOU CAN NOT HAVE SURGERY IF YOU ARE PREGNANT OR MIGHT BE: A PREGNANCY TEST WILL BE ORDERED UNLESS YOU CAN SIGN THAT YOU ARE CERTAIN YOU ARE NOT PREGNANT)

Height ___________ Weight_____________

Have you gained or lost weight in the past two years_________ How much_____

Do you smoke? __________ What? __________
How much? ________

Do you drink alcohol? _______ What? __________
How much? __________

Contact lenses?_______ Dentures? ____________

Heart, bone or breast prosthesis? ____

Do you take aspirin, herbal or other non-prescription drugs______

Please list ____

____

____

Please list all other prescription or self-administered drugs

____

____

____

____

____

ALLERGIES:
Please circle any:

Penicillin Latex Iodine Adhesive tape

Sulfa Keflex Aspirin Tetracyclines

Sedatives Barbiturates Jewelry

Anesthesia Agents Local Anesthesia

Other agent or food or drug

____

PRIOR COSMETIC SURGERY: (TYPE & DATES)____

OTHER PRIOR OPERATIONS: (TYPE & DATES)

____

REVIEW OF SYSTEMS
CIRCLE ANY THAT YOU HAVE NOW OR IN THE PAST

Bleeding Heavy scars or keloid anemia Aids

Alcohol abuse artificial joints heart valves asthma

Drug abuse Shortness of breath Chest pain

Passing out Rheumatic fever Depression

Anxiety Attacks Liver disease Kidney Disease

Hay fever High blood pressure glaucoma

Pacemaker Stroke MI TB Sinus Shingles

Hepatitis Herpes HIV STD VD Warts

Epilepsy Seizures Other

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____

THE ABOVE INFORMATION IS CORRECT , AND I AGREE TO ALLOW DR. McAVOY TO OBTAIN MEDICAL INFORMATION NECESSARY TO MY CARE : (NOTE HERE ANY EXCEPTIONS)____

SIGNATURE DATE