MICHAEL BUBLIK, M.D.
Facial Plastic Surgery
Otolaryngology - Head and Neck Surgery
Allergy

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name_____ **First** _____ **MI** _____

Address _____**Zip Code:** _____

Phone Number_____ **SSN (REQUIRED)** _____

Driver's License/ ID Number_____

Sex: ☐ Male ☐ Female **Race:** _____ Ethnicity**:** _____ **Date of Birth:** _____

Email: _____ **Interested in Cosmetic Procedures?** ___Yes ___No

Preferred Language: _____ **Name of Primary Care Physician:** _____

Primary Insurance: _____ **Secondary Insurance:**_____

Subscriber Number: _____ **Subscriber Number:**_____

Group Number: _____ **Group Number:**_____

Emergency contact Name: _____ **Relationship:**_____

Contact info: _____

Pharmacy Preference (include location):_____

Referral Source (Check all that may apply): ☐ Google ☐Yahoo ☐ Yelp ☐Facebook ☐Instagram ☐Other website

☐Friend _____☐Physician_____

Other (Please specify) _____

Preferred Language: ☐ English ☐Armenian ☐Russian ☐Spanish ☐Other:_____

Medical History: ☐ Heart Disease ☐High Cholesterol ☐Stroke ☐Diabetes ☐High Blood Pressure

☐Heart Attack ☐Liver Disease ☐Kidney Disease ☐Tuberculosis ☐Hepatitis C ☐HIV/AIDS ☐Depression

☐ Cancer (please list): _____

MICHAEL BUBLIK, M.D.
Facial Plastic Surgery
Otolaryngology - Head and Neck Surgery
Allergy

☐ Other (please list):_____

REASON FOR TODAY'S VISIT: _____

SYMPTOMS YOU ARE HAVING: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? ____ **Yes** ____ **No** If yes, please list below:

Name of Medication	Type of Reaction

ARE YOU CURRENTLY TAKING BLOOD THINNERS? ____ **Yes** ____ **No** If yes, please list below:

Name of Medication

SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ____Yes ____No
If yes, please list type of problems: _____
_____
_____

List any surgeries you have had (including dates):
_____
_____
_____

Have you ever been hospitalized for non-surgical reasons? ___Yes ___ No
If yes, list reasons for hospitalizations _____

Height _____Weight _____BP_____/_____