ALFONSO BARRERA, M.D., F.A.C.S.

All of the following information is strictly confidential and necessary for your optimal care.

Patient's Name	Pharmacy Phone Number

Reason for your appointment. (Please Be Specific) If because of an injury, please give date.

Referred By: (Choose) ◯ Health & Fitness ◯ SWBY ◯ Internet ◯ Mall Advertisement

◯ Dr. _____ ◯ Other _____

Are you allergic to any medications? If yes, Please List.

Are you allergic to Local Anesthetics? If yes, Please List.

Specifically are you allergic to penicillin?	◯	YES	◯	NO	
If so, what kind of reaction do you have?					
Do you have or have you ever had hayfever or asthma?	◯	YES	◯	NO	
Are you taking any of the following medications?					
Cortisone drugs, Steroids or ACTH	◯	YES	◯	NO	
Tranquilizers or Sedatives	◯	YES	◯	NO	
Anticoagulants or Blood Thinners	◯	YES	◯	NO	

List any current medications:

List any and/or all surgeries the patient has had under general anesthesia and list any complications during previous surgeries.

List any illness that has required hospitalization

Height	Weight	Do you smoke?	◯	YES	◯	NO
How many packs per day?		For how long?				
Do you drink any alcoholic beverages?	◯	YES	◯	NO		
How often?		How much?				

Have you ever had?	(Please Check:)	Have you ever had?	(Please Check:)	
Heart Trouble	☐	Blood Disease	☐	
High Blood Pressure	☐	Prolonged Bleeding	☐	
Irregular Heart Beat	☐	Anemia	☐	
Fainting Tendencies	☐	Diabetes	☐	
Shortness of Breath	☐	Frequent Thirst	☐	
Chest Pain	☐	Psychiatric Treatment	☐	
Tuberculosis	☐	Hepatitis	☐	What Type?
Seizures	☐	Acid Reflux	☐	
Kidney Trouble	☐			

Have you had an H.I.V. Antibody Test (AIDS)?	(Choose)	◯	YES	◯	NO
If yes, what was the result?	(Choose)	◯	Positive	◯	Negative

Do you have any medical conditions not listed above?

Signature _____ Date _____