

## REFERRAL SURVEY

(Please choose the one answer which is most appropriate)

- RECOMMENDED BY A **FRIEND OR RELATIVE**  
NAME OF PERSON \_\_\_\_\_
- INSURANCE BOOKLET**
- REFERRED** BY MY PHYSICIAN  
PHYSICIAN'S NAME \_\_\_\_\_
- RECEIVED **FLYER** IN MAIL
- SAW **SIGN** ON BUILDING
- NEWSPAPER AD**  
NAME OF NEWSPAPER \_\_\_\_\_
- BILLBOARD**  
WHERE \_\_\_\_\_
- TELEVISION**  
WHICH STATION \_\_\_\_\_
- RADIO AD**  
WHICH STATION \_\_\_\_\_
- INTERNET**
- YELLOW PAGES**
- OTHER**  
PLEASE SPECIFY: \_\_\_\_\_

### MEDICAL QUESTIONS

ALLERGIC TO ANY MEDICATIONS? \_\_\_\_\_ NO \_\_\_\_\_ YES

IF YES, PLEASE LIST THEM: \_\_\_\_\_  
\_\_\_\_\_

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DO YOU NEED TO TAKE ANTIBIOTICS BEFORE DENTAL OR SURGICAL PROCEDURES, OR HAVE A HISTORY OF RHEUMATIC FEVER, RHEUMATIC HEART DISEASE, OR HEART VALVE PROBLEMS? \_\_\_\_\_ NO \_\_\_\_\_ YES

DO YOU HAVE A BLEEDING DISORDER, BLEED ABNORMALLY AFTER SURGERY, OR TAKE MEDICINE THAT THINS YOUR BLOOD; SUCH AS ASPIRIN: \_\_\_\_\_ NO \_\_\_\_\_ YES

LIST PREVIOUS HOSPITALIZATIONS/SURGERIES:  
\_\_\_\_\_  
\_\_\_\_\_

LIST MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY:  
\_\_\_\_\_

#### PLEASE LIST YOUR PERSONAL PHYSICIAN:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

REASON FOR VISIT \_\_\_\_\_

### Do you have any problems with the following body functions? (If yes, please explain.)

- NO YES IF FEMALE, ARE YOU PREGNANT?  
DATE DUE: \_\_\_\_\_
- NO YES GENITALIA: \_\_\_\_\_ LAST MENSES: \_\_\_\_\_
- NO YES NEUROLOGICAL/PSYCHIATRIC: \_\_\_\_\_
- NO YES LIVER, KIDNEY OR URINARY: \_\_\_\_\_
- NO YES STOMACH OR BOWELS: \_\_\_\_\_
- NO YES EYES, EARS, NOSE, OR THROAT: \_\_\_\_\_
- NO YES MUSCLES OR JOINTS: \_\_\_\_\_
- NO YES HEART OR LUNGS: \_\_\_\_\_
- NO YES THYROID: \_\_\_\_\_
- NO YES SKIN: \_\_\_\_\_

### Have you had any of the following conditions?

- NO YES BLOOD TRANSFUSION? PLEASE EXPLAIN  
CIRCUMSTANCES: \_\_\_\_\_
- NO YES KELOID OR LARGE SCARS/POOR SCARS
- NO YES DIFFICULTY WITH ANESTHESIA?  
EXPLAIN: \_\_\_\_\_
- NO YES HISTORY OF MELANOMA OR SKIN CANCER
- NO YES RADIATION TREATMENT FOR TUMORS
- NO YES ALLERGIES TO EGGS OR SOYBEANS
- NO YES COLD SORES OR FEVER BLISTERS
- NO YES MALIGNANT HYPERTHERMIA
- NO YES PREVIOUS ACCUTANE USE
- NO YES HISTORY OF BLOOD CLOTS?
- NO YES HIGH BLOOD PRESSURE
- NO YES CANCER OR LEUKEMIA
- NO YES HEPATITIS OR HIV
- NO YES DIABETES
- NO YES SEIZURES
- NO YES ALCOHOL USE? HOW MUCH? \_\_\_\_\_
- NO YES DO YOU SMOKE? HOW MUCH? \_\_\_\_\_