

# REFERRAL SURVEY

WHY DID YOU SELECT THIS OFFICE?  
(Please choose the one answer which is most appropriate)

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

## MEDICAL QUESTIONS

ALLERGIES 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?<br>DATE DUE: _____ |
| NO | YES | GENITALIA: _____ LAST MENSES: _____             |
| NO | YES | NEUROLOGICAL/PSYCHIATRIC: _____                 |
| NO | YES | LIVER, KIDNEY, OR URINARY: _____                |
| NO | YES | STOMACH OR BOWELS: _____                        |
| NO | YES | EARS, NOSE, OR THROAT: _____                    |
| NO | YES | MUSCLES OR JOINTS: _____                        |
| NO | YES | HEART OR LUNGS: _____                           |
| NO | YES | THYROID: _____                                  |
| NO | YES | EYES: _____                                     |
| 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?<br>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? _____                          |