

Chernoff Plastic Surgery and Laser Center
830 Second Street
Santa Rosa, CA 95404

PLEASE FILL OUT THE INFORMATION BELOW AS CONCISELY AS POSSIBLE:

NAME: _____ AGE: _____ SEX: _____ BIRTHDATE: _____

OCCUPATION: _____ FAMILY DOCTOR: _____

FAMILY ILLNESSES:

YES NO

	YES	NO
DIABETES		
HIGH BLOOD PRESSURE		
CANCER		
HEART DISEASE		
OTHER		

PAST ILLNESSES OR

INJURIES: _____

OPERATIONS: _____

VITAMINS (TYPE, STRENGTH, DOSAGE): _____

M

EDICATIONS: _____

ALLERGIES (TO MEDICATION, HAY FEVER, ETC.): _____

HABITS (TOBACCO, ALCOHOL, ETC.): _____