Semone Rochlin D.O.
COSMETIC & RECONSTRUCTIVE SURGEON
BOARD CERTIFIED GENERAL SURGEON

# PATIENT INFORMATION

Patient Full Name_____ Date_____

Current Address_____SS#_____

City, State, Zip_____Home #_____

Date of Birth_____Age_____Gender_____Cell #_____

Email Address_____Emergency Contact & Phone #_____

## GENERAL HEALTH INFORMATION

Past Medical History_____

_____

_____

Past Surgical History_____

_____

_____

Gynecologic History (Female)_____

_____

_____

Allergies to any medications or foods_____

_____

Do you smoke? (y/n)_____ If yes, # of years?_____ I smoke: Cigarettes____Cigars_____ How many per day?_____

Alcohol use? (y/n)_____ # of beer/wine/liquor (please circle) per day/week_____

Occupation_____Number of years in this occupation_____

| MEDICATIONS/PRESCRIPTIONS | ALLERGIES & WHAT THEY CAUSE | VITAMINS/HERBS/MINERALS |
|---|---|---|
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I certify that the inquiries set forth above have been answered to the best of my knowledge and recollection. I will not hold Dr. Rochlin or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form

X_____Date_____

Signature of Patient or Responsible party