Eduardo G. Barroso, M.D., FACS

PATIENT NAME				TODAY'S DATE
ADDRESS	CITY	STATE	ZIP	
SOCIAL SECURITY #	DATE OF BIRTH	AGE	PLACE OF BIRTH	GENDER Ï MALE Ï FEMALE
HOME PHONE #	WORK PHONE #	MOBILE PHONE #		EMAIL ADDRESS Ï PRIVATE?
OCCUPATION	EMPLOYER	SPOUSE OR PARENTõS NAME		
EMERGENCY CONTACT	RELATIONSHIP	HOME PHONE #	WORK PHONE #	
PRIMARY CARE PHYSICIAN		PHONE #		
REFFERED BY:				

CONFIDENTIALITY OF MEDICAL INFORMATION

I **would** like medical information to only be given to (please list the name of every person you would like medical information released to, including any physicians, family members, spouse, significant other, children, grandchildren, friends, etc.):

_____

_____

I **do not want** any medical information released to the following individuals (please include physicians, family members, spouse, significant other, children, grandchildren, friends, etc.):

_____

_____

PATIENT'S SIGNATURE_____

MALPRACTICE INSURANCE

ñUnder Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. ***YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.*** This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.ò

PATIENT'S SIGNATURE _____

EDUARDO G. BARROSO, M.D., FACS

PATIENT:_____ Age: _____ DOB: _____

Height:_____ Present Weight:_____ Maximum Adult Weight:_____

Reason for seeing the doctor:_____

Past Medical History (have you ever had)…

Ĭ Stroke	Ĭ Breast Lump or Cancer	Ĭ Pneumonia	Ĭ Bloody Stools
Ĭ Seizures	Ĭ Other Cancer	Ĭ High Blood Pressure	Ĭ Kidney Disease
Ĭ Fainting Spell	Ĭ Abnormal Clotting	Ĭ Chest pain	Ĭ Kidney Stones
Ĭ Frequent Headaches	Ĭ Pulmonary Embolism	Ĭ Heart Attack	Ĭ Painful Urination
Ĭ Visual Problems	Ĭ Deep Vein Thrombosis	Ĭ Swollen Ankles	Ĭ Bone or Joint Disease
Ĭ Use of eyeglasses or contact lenses	Ĭ Bleeding Disorders	Ĭ Rheumatic Heart	Ĭ Rheumatoid Arthritis
	Ĭ Rashes or Skin Disease	Ĭ Mitral Valve Prolapse	Ĭ AIDS / HIV
Ĭ Dry Eyes or Infection	Ĭ Sudden Weight Loss	Ĭ Heart Disease	Ĭ Herpes/Shingles/ Cold Sores
Ĭ Neurologic Disease	Ĭ Night Sweats	Ĭ Hepatitis / Jaundice	Ĭ Poor Healing Wounds
Ĭ Diabetes	Ĭ Lupus Erythematosis	Ĭ Ulcerative Colitis	Ĭ Keloids or Unsightly Scars
Ĭ Easy Bruising	Ĭ Collagen Vascular Disease	Ĭ Crohnôs Disease	Ĭ Anxiety Disorder
Ĭ Swollen Lymph Nodes	Ĭ Nasal Obstruction	Ĭ Gallbladder disease	Ĭ Depression
Ĭ Anemia	Ĭ Asthma/Emphysema	Ĭ Acid Reflux	Ĭ Other Psychiatric Condition
Ĭ Thyroid Disease	Ĭ Shortness of Breath	Ĭ Ulcers	Ĭ Hospital Admission
Ĭ Fibromyalgia	Ĭ Sleep Apnea/Severe Snoring	Ĭ Hernia	Ĭ Blood Transfusion
Ĭ Scleroderma	Ĭ Chronic Cough	Ĭ Frequent Nausea/ Vomiting/Diarrhea	Ĭ Anesthesia complications
Ĭ Chronic Fatigue	Ĭ Tuberculosis		Ĭ Other Illness or Injury

Last date seen by primary care physician: _____

Surgical History…

If you have had any operations, please list them here:

Date	Location	Operation	Surgeon	Complications

Have you had any injections for cosmetic enhancement (Botox, Collagen, Restylane, etc.): Ĭ Yes Ĭ No

Please indicate if you have ever experienced any complications or adverse reactions from anesthesia:

Local Anesthesia: Ĭ Yes Ĭ No
General Anesthesia: Ĭ Yes Ĭ No
Spinal / Epidural: Ĭ Yes Ĭ No

If yes, to any questions please explain:_____
_____
_____
_____

Women Patients Only…

Date of last mammogram: _____
Present bra size (breast patients only): _____
Maximum bra size: _____
Last menstrual period: _____
Could you be pregnant now: _____

Number of pregnancies: _____
Number of children: _____
Number of vaginal deliveries: _____
Number of C-sections: _____

Medications… List dose or number of pills per day:

Prescription Drugs:

_____
_____
_____
_____
_____
_____

Non- Prescription (vitamins, herbal medications, etc.):

_____
_____
_____
_____
_____
_____

Regular use of Aspirin or Aspirin Products: Ĭ Yes Ĭ No

Regular use of blood thinners (Coumadin, Heparin, etc.): Ĭ Yes Ĭ No

Regular use of Vitamin E: Ĭ Yes Ĭ No

Regular use of Non-Aspirin pain relievers (Ibuprofen, Aleve, etc.): Ĭ Yes Ĭ No

Use of corticosteroids over the last 6 months (Prednisone, Cortisone, etc.): Ĭ Yes Ĭ No

Allergic Reactions to…

Penicillin:	Ĭ Yes	Ĭ No	If yes, please describe the type of reaction: _____
Other Drugs:	Ĭ Yes	Ĭ No	_____
Latex:	Ĭ Yes	Ĭ No	_____
Tape:	Ĭ Yes	Ĭ No	_____
Iodine:	Ĭ Yes	Ĭ No	_____

Social Habits…

Do you smoke? _____ How much? _____

Do you drink alcohol? _____ How much? _____

Have you used recreational drugs in the last 6 months? Ĭ Yes Ĭ No

Family History…

Ĭ Diabetes
Ĭ Stroke
Ĭ Seizures
Ĭ Abnormal Clotting
Ĭ Bleeding Disorders
Ĭ High Blood Pressure
Ĭ Heart Disease / Attack

Ĭ Ovarian or Uterine Cancer
Ĭ Breast Cancer
Ĭ Other Cancer
Ĭ Kidney Disease
Ĭ Complications from Anesthesia
Including **Malignant Hyperthermia ***
* (High Fevers during Anesthesia)

Ĭ Other Serious Illness

Please Describe:

_____
_____
_____
_____

*I certify that I have completed this form and that **ANY BLANK LINES OR BOXES IMPLY A NEGATIVE RESPONSE.***

_____ _____

Patient's Signature ***Date***