**BERNARD L. MARKOWITZ, M.D., F.A.C.S.**
**A MEDICAL CORPORATION**
**9675 BRIGHTON WAY, SUITE 350 BEVERLY HILLS, CA 90210**
**Tel: (310) 205-5557 Fax: (310) 205-5595**

## PATIENT INFORMATION

Name: _____ Age: _____ Sex: _____

Address:_____City:_____ State: _____ Zip:_____

Billing Address:_____City:_____State:_____ Zip:_____

Home Phone :_____ Mobile / Pager # _____

Birthdate: _____S.S. No. _____ Height: _____ Weight: _____

Single: _____ Married: _____Widowed: _____Divorced: _____ Occupation: _____

Employed By:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Spouse's Name:_____ S.S. No.:_____

Employed By:_____ Phone: _____

Address:_____ City:_____ State:_____ Zip:_____

Person to Contact in Case of Emergency: _____

Relationship:_____ Phone:_____

Insurance Carrier:_____ Policy #:_____

Who referred you to the Doctor? _____Phone:_____

I irreversibly assign to Dr. Bernard Markowitz all my right, without limitation, pertaining to my insurance carrier relating to services that Dr. Markowitz provided to me. I understand and agree that Dr. Markowitz may pursue those rights through demand letters, settlement, and litigation until finished, and that Dr. Markowitz will keep all money paid by my insurance carrier. I understand and agree that Dr. Markowitz may irreversibly reassign such matters and payments to someone else in order to pursue these matters. I direct my insurance carrier to pay all sums directly to Dr. Markowitz or to the party receiving the reassignment.

**I, _____, HAVE CAREFULLY READ AND UNDERSTAND THIS ASSIGNMENT, AND**

**ACCEPT, APPROVE, AND AGREEE TO THIS ASSIGNMENT**.

_____ _____
AUTHORIZED SIGNATURE DATE

**Medical History Questionnaire**
**(Confidential Information)**

Patient's Name: _____ Date:_____

Reason for Visit: _____

MEDICAL HISTORY: Please check the following

| | | | |
|---|---|---|---|
| High Blood Pressure…….. | yes___ no___ | Skin Disease……. | yes___ no___ |
| Bleeding Disorder…… | yes___ no___ | Thyroid Disease…… | yes___ no___ |
| Anemia……..…….. | yes___ no___ | Lung Disease…….. | yes___ no___ |
| Liver Disease…..……. | yes___ no___ | Tuberculosis…… | yes___ no___ |
| Heart Disease……. | yes___ no___ | Shortness of Breath…….. | yes___ no___ |
| Psychiatric Illness…….……. | yes___ no___ | Hepatitis……...… | yes___ no___ |
| HIV……..… | yes___ no___ | Diabetes…… | yes___ no___ |

Please list any other medical history the doctor should be aware of:

_____

_____

Please list any prior hospitalizations below (e.g. accidents etc.):

_____

_____

FAMILY HISTORY: Please give the age of living or if deceased, cause of death and age of deceased.

Father:_____ Mother:_____

Siblings:_____ Children:_____

MEDICATIONS: Please list medications you currently take, including <u>appetite suppressants, vitamins, herbal supplements or any homeopathic medication:</u>

_____

Do you take any aspirin or any aspirin containing compound? ____ If "YES" for what reason? _____

Do you have any ALLERGIES and/or SENSITIVITIES: (please indicate which, if any are present):

| | | | |
|---|---|---|---|
| Penicillin…….…… | yes___ no___ | Aspirin…… | yes___ no___ |
| Sulfa…… | yes___ no___ | Xylocaine…… | yes___ no___ |
| Any Other Antibiotics…… | yes___ no___ | Adhesive Tape……..… | yes___ no___ |
| Codeine……. | yes___ no___ | Tetanus Toxoid…… | yes___ no___ |

Any Other……. _____

SOCIAL HISTORY:

Cigarette Smoking:…… yes___ no___ How long since last use? _____

Alcohol Use:…….. yes___ no___ Drugs: _____

Caffeine: None _____ Daily_____ How much?_____

Do you take Vitamin E? _____ If "YES" how much? _____

SURGICAL HISTORY:

Please list all previous surgeries/operations, including cosmetic:

_____ Date_____

_____ Date_____

_____ Date_____

_____ Date_____

Please list any complications or problems you experienced during or following the above procedures:

_____

Do you wear corrective eye glasses or contacts? _____ Date of last ophthalmology (eye) check up? _____

Have you recently been under the care of a physician for any reason? Yes_____ No_____

If "YES" please explain:

_____

Family Physician: _____ Date of last check up: _____

Address: _____ Phone: _____

Note: If you are scheduled for surgery at anytime, please be advised that you cannot take aspirin or aspirin containing products for a period of two weeks prior to your surgery. Evidence suggests that even small amounts of aspirin or other anti-inflammatory products can create bleeding problems in the apparently healthy adult. Acetaminophen, such as Tylenol may be used as a substitution for aspirin.