Ramsey J. Choucair, M.D., FACS
9301 N. Central Expressway, Suite 551
Dallas, TX 75231
T:214-389-9797 F:214-389-9799
contactus@drchoucair.com

Date_____

_____ _____ _____
Name **DATE OF BIRTH** **AGE**

_____
Street Address **City/State** **Zip**

Cell_____ **Home**_____

SS#_____ **Email:**_____

_____
Employer **Occupation** **Work Phone**

_____
Emergency Contact Name **Telephone Number** **Relationship**

Who referred you to Dr. Choucair _____

Primary Care Physician_____ **Phone #**_____

Reason for visit_____

Confidential Medical History

Height_____ **Weight**_____

Please list any previous surgery: _____

_____

Please list all current medications (include herbs, vitamins/supplements, aspirin)_____

_____

Are you allergic to any medications? Please list_____

_____

Have you or your family members had unusual reaction to anesthesia (muscle weakness, jaundice, or unusual fever) Yes or No

Do you have, or have you had any of the following:

___ Mitral Valve Prolapse	**____Anemia or Blood Disorder**	**_____Asthma**	**___ Contact Lenses**
____Irregular Heartbeat	**____Blood Transfusions**	**_____Diabetes**	**____Seizures**
____Heart Condition	**____Bleeding Problems**	**_____Dry Eyes**	**____Cancer**
____High Blood Pressure	**____Thyroid Problems**	**_____Steroid Use**	**____Hepatitis**
____Kidney or Bladder Problems	**____Keloids or "thick scars"**	**_____Blood Clots/Deep Venous Thrombosis**	

Do you smoke? Yes or No How much:_____ **Do you drink alcohol? Yes or No**

Previous number of pregnancies_____ **Number of births**_____