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Date of Appointment: \_\_\_\_\_ Provider: \_\_\_\_\_

Patient's Legal Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

**Past Medical/Family History:** Check if you personally have or anyone in your family has:

	Self	Relative		Self	Relative		Self	Relative
Allergies			Asthma			Arthritis		
Eczema			Lung Disease			Diabetes		
Hay Fever			Skin Cancer			Heart Disease		
Hives			Malignant Melanoma			Hypertension		
Psoriasis			Other Cancer			Tuberculosis		

**Current or Past Problems With:**

	Yes	No	If yes, explain
General Health			
Eyes			
Ear/Nose/Throat/Mouth			
Heart			
Lungs			
Stomach/Bowel			
Kidneys			
Arthritis/Muscles/Joints			
Skin			
Headaches/Seizures			
Psychiatric			
Thyroid/Diabetes			
Blood/Bleeding Disorder			
Allergic/Immunologic			

Major Medical Illnesses/Surgeries: \_\_\_\_\_

**Females:** Are you pregnant?  Yes  No      Planning to become pregnant?  Yes  No

**Social History:**

Do you use alcohol? (Include frequency) \_\_\_\_\_ Do you smoke? (Include frequency) \_\_\_\_\_

Hobby/Leisure Activities: \_\_\_\_\_