

BRADFORD TRUE PRESCOTT, M.D.
100 N. Wiget Ln. Suite #100, Walnut Creek CA 94598
(925) 935-9717

Dear Patient: All of the following information is for the sole purpose of taking better care of you before and after surgery. It is confidential and will not be released without your written authorization. I thank you for taking this time to help me know more about you.

First name: _____ Lastname: _____ Height: _____ Weight: _____ Age: _____

What procedure(s) do you wish to discuss with Dr.Prescott? _____

Please list any allergies you have to medicines, and how you reacted:

Number of children: _____ Ages: _____ Do you smoke? _____ Packs/day? _____ No. of years: _____
How much alcohol per day? _____ type: _____ Menopause? _____ If yes, age of menopause: _____

Please list all previous serious illnesses and dates:

Illness: _____ Date: _____
Illness: _____ Date: _____

Please list any injuries and dates:

Injury: _____ Date: _____
Injury: _____ Date: _____

Please list all previous operations, any complications, and dates:

Operation: _____ Date: _____ Complications? _____
Operation: _____ Date: _____ Complications? _____
Operation: _____ Date: _____ Complications? _____

Have you ever had a blood transfusion? _____ When? _____

Have you had any problems with the following organs or diseases? (please circle area problems have occurred)

Thyroid	Liver	Heavy Menses	Gallbladder	Hepatitis
Heart	High Blood Pressure	Ulcers	Arthritis	HIV / AIDS
Lungs (breathing)	Asthma	Diabetes (sugar)	Brain	Easy Bruising
Kidneys	Stroke	Bleeding Gums	Stomach	Anxiety
UrinaryBladder	Cancer	Excessive bleeding		

Have you ever had an HIV test performed? _____ Date: _____ Results: _____.

Family physician: _____ Mailing Address: _____
Phone number: _____

List all medications, both prescription and over-the-counter, that you take (include dosage):

How did you come to learn about Dr. Prescott? (circle)

Yellow Pages Ad	Contra Costa Times	Friend	Doctor	
Heard him lecture	Inamed Breast Advertising		Diablo Magazine	Radio
T. V.	San Francisco Chronicle			

The above information is accurate and true to the best of my knowledge. I have not purposefully left out pertinent information or given inaccurate information.

Patient or Parent Signature: _____

Date Signed: _____