WELCOME TO THE OFFICE OF HAKAN M. KUTLU, M.D.

Last Name_________________________First______________________Middle____________

Address____

Occupation____

Age_____ Sex: M F Ht: __' ___" Wt:_____lbs. Marital Status: S M W D

Primary Physician____________________ Last Physical Examination_________________

DO YOU HAVE OR HAVE YOU HAD : (check all that apply)

¡ Seasonal allergies	¡ Hepatitis	¡ Bleeding tendency
¡ Pneumonia	¡ Stomach ulcers	¡ Stroke
¡ Bronchitis	¡ Colitis	¡ HIV / AIDS
¡ Asthma	¡ Kidney problems	¡ Migraine headaches
¡ Tuberculosis	¡ Bladder infection	¡ Epilepsy
¡ Hypertension	¡ Thyroid problems	¡ Gynecologic problems
¡ Heart disease or attack	¡ Diabetes	¡ Nervous Breakdown
¡ Cancer	¡ Arthritis	¡ Psychiatric treatment
¡ Leukemia	¡ Bone fractures	¡ Drug / Substance abuse treatment

Do you smoke regularly? Y___ N____ How much? _____ How many years? _____
Date of last chest x-ray _______________
Do you drink alcohol? Y____ N____ Amount / Frequency? _____________
Have you ever had an adverse reaction to any type of anesthesia? Y____ N____
Do you take Ibuprofen or Aspirin regularly? Y____ N____ How often? ________
Do you have a history of excessive bleeding following any procedure? Y____ N____
Do you have a living will? Y____ N____

ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS?

___Aspirin	___Heart Medication	___Sleeping Pills
___Advil, Ibuprofen	___Digoxin	___Tranquilizers
___Hormones	___Barbiturates	___Cortisone
___Birth Control	___Dilantin	___Blood Thinning Pills
___Water Pills	___Antibiotics	___Blood Pressure Pills
___Thyroid Pills	___Iron supplements	

PLEASE LIST ALL CURRENT MEDICATIONS AND DOSAGES

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

Write in the names and years of any operations which you have had: ____________________
____
____

Name any drugs to which you are allergic: ____
____

Serious illnesses or injuries which you have had:____________________________________
____

FAMILY HISTORY

Father		Age	Medical Problems
Living	Deceased	___	________________________________
Mother			
Living	Deceased	___	________________________________

Brother(s)	Age(s)	Medical Problems
________	_____	________________________________
________	_____	________________________________

Sister(s)	Age(s)	Medical Problems
_______	_____	________________________________
_______	_____	________________________________

WOMEN ONLY

Are you still having regular monthly menstrual periods? Y____ N____
Have you ever had discharge from the nipple of your breast? Y____ N____
Do you regularly have PAP smears of the cervix? Y____ N____ Date of last test?_______
How many pregnancies? ________ Caesarean deliveries? Y____ N____
Date of last mammogram? ________