Timothy J. Mickel M.D., F.A.C.S.

Timothy J. Mickel, M.D., F.A.C.S.
903 North 2nd. Street
Monroe, LA 71201
(318) 388-2050

Date ______________
ACCT# ______________
REFERRED BY: __________

General Health Information

(Please Print Clearly)

NAME ______________________ REFERRING PHYSICIAN ______________________
DATE OF BIRTH ______________________ HEIGHT ______________________
AGE ______________________ WEIGHT ______________________

REASON FOR VISIT:

____

IS CONDITION/INJURY WORK RELATED? YES ☐ NO ☐

PAST MEDICAL HISTORY

Medical: Do you now have, or have you ever had, any of the following disorders?

☐ *Diabetes*	☐ *Cancer*	☐ *Excessive Bleeding*
☐ *High Blood Pressure*	☐ *Hepatitis*	☐ *Anemia or other Blood Disorder*
☐ *Heart Attack*	☐ *Kidney Problems*	☐ *Seizures*
☐ *Irregular Heart Beat*	☐ *Difficulty Urinating*	☐ *Psychiatric Problems*
☐ *Heart Murmur*	☐ *Thyroid Problems*	☐ *Nerve Problems*
☐ *Rheumatic Fever*	☐ *Ulcers*	☐ *Sinus Problems*
☐ *Chest Pain*	☐ *Bowel Problems*	☐ *Decreased Vision*
☐ *Shortness of Breath*	☐ *Easy Bruising*	☐ *Dry Eye*
☐ *Asthma*	☐ *Stroke*	☐ *Excessive Tearing*
☐ *Other Lung Disease*	☐ *Poor Circulation*	☐ *Wound Healing Problems*
		☐ *Keloids or Excessive Scar Formation*

Any conditions or illnesses not listed above? ______________________________

____

____

Surgical: Please list all operations you have had, including hospitals and dates, if known.

____

____

____

____

Medications: Please list all medications you are currently taking. ______________________
INCLUDE NAME, DOSAGE (mg., gm., etc.) and FREQUENCY. ______________________
(Include Aspirin, Birth Control Pills, Vitamins, Etc. ______________________

____

____

Allergies: Drug Allergies (list) ______________________ Other: (tape, iodine, soaps, etc.) ______________________

____

Other: Do you smoke? ______ Approx. packs/day? ______ Do you drink? ______ Approx. amount/week? ______
List any diseases that run in your family: ______________________