MONTE O. HARRIS, MD

MR./MS./MRS./DR					Date:	
	First	M.I.	Last			
HOW DID YOU HEAR	ABOUT US?					
WHAT IS YOUR OBJE	CTIVE FOR Y	OUR VISIT ?				
PHONE NUMBERS						
HOME:		MOBIL	.E:			
WORK:		EMAIL:				
ADDITIONAL INFORM	MATION					
ADDRESS:						
STRE	ET AF	PT/SUITE	CITY	STATE	ZIP CODE	
DATE OF BIRTH:			OCCUPATION	:		
ETHNIC ORIGIN:						
MEDICAL INFORMAT	TON					
LIST ALLERGIES:						
LIST ALL CURRENT PR	RESCRIPTIONS	(INCLUDING	S ASPRIN):			
LIST ALL CURRENT NU	UTRITIONAL A	AND VITAMIN	N SUPPLEMENTS			
DO YOU HAVE A HISTO	ORY OF BRUIS	SING OR BLEE	EDING PROBLEN	1S: AI	RE YOU PREGNANT?	
PLEASE LIST ANY SIG	NIFICANT MEI	DICAL PROBL	LEMS:			
LIST ALL PREVIOUS S	URGERIES (INC	CLUDING CO	SMETIC):			
SKIN CARE						
HOW DO YOU CURREN	NTLY TAKE CA	ARE OF YOUR	SKIN? (i.e. brand	names, manufac	turers, etc)	
MORNING:						
EVENING:						