

WELCOME TO OUR OFFICE

GENERAL MEDICAL INFORMATION

Patient Name: _____

Reason for Today's Appointment: _____

How Long has this been a problem: _____

What treatment has been prescribed for the above: _____

Please list: Height _____ Weight _____

Do you smoke? Yes No If Yes, Packs per Day _____ How Long have you smoked? _____

Have you ever smoked? Yes No If Yes, Packs per Day _____ How long? _____ When did you quit? _____

Do you chew tobacco? Yes No How much? _____

Do you drink alcohol? Yes No How much? _____

PERSONAL MEDICAL HISTORY

Have you ever had any of the following? (Check ALL that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Convulsions/epilepsy | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Any Heart Problems | <input type="checkbox"/> Neuro-Muscular Problems | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Stomach Disease |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Anemia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Restless Sleep |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Other _____ |

SURGICAL HISTORY

Please list any previous surgeries and the year surgery was performed. _____

Do you have any objection to the use of blood products in the unlikely event they should become necessary? Yes No

Have you or any family member had a reaction to any local or general anesthetic? Yes No

If Yes, what type of reaction? _____

FAMILY HISTORY

Does anyone in your immediate family have a history of any of the following? (Check ALL that apply)

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney or Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other _____ |

ALLERGIES

Do you have any allergies to medications? Yes No

If Yes, please list:

Medication	Type of Reaction
_____	_____
_____	_____
_____	_____

Allergic to Latex? Yes No

Allergic to x-ray dye? Yes No

MEDICATIONS

Are you taking any medications on a regular basis? Yes No

List all Medications you are currently taking:

Medication	Dose	Medication	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT SIGNATURE _____ DATE _____ STAFF _____