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Patient Information

Patient Name: _____ D.O.B: _____
Last First MI

Health Information

Have you ever had any of the following? Please check those that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous disorders |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Gout | <input type="checkbox"/> Radiation treatments |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head injuries | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Bladder disease | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Bowel disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Venereal disease |

OTHER:

- Have you ever had any complications following a procedure? Yes No
If yes, please explain:
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain:
- Are you now under the care of a physician? Yes No
If yes, please explain:
- Name of Physician: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

****PLEASE LIST ALL CURRENT MEDICINES AND DRUG ALLERGIES ON THE REVERSE SIDE →→**

Signature of patient, parent, or guardian: _____ Date: _____

Have you ever smoked? Yes No

Do you currently smoke? Yes No

If yes, how many years? _____ When did you stop? _____

How much per day? _____

How many alcoholic drinks per day _____

per week _____

per month _____

Pharmacy name and address: _____

MEDICINES:

DRUG ALLERGIES: