

Patient Name _____

Chart # _____ Date _____

General Information

Height _____ Weight _____ Referring Physician _____
Occupation _____ Your Family Physician _____

Personal History

Do you have or have you ever had any of the following health problems? (check all that apply)

- High Blood Pressure Kidney Problems Allergies
 Heart Disease Glaucoma Asthma, Lung Disease, persistent cough
 Diabetes Hepatitis Acquired Immune Deficiency Syndrome
 Arthritis Bleeding Problems Cancer
 Other (Please specify) Pacemaker

List any medications, including birth control pills and aspirin you take on a regular basis. (Specify dosage)

_____ Dosage: _____ _____ Dosage: _____
_____ Dosage: _____ _____ Dosage: _____

Are you allergic to: Penicillin Iodine Tetracycline Sulfa Novocaine Codeine

Other: (include any medicine, food, inhalants, etc.)

Family History

Are there any medical problems in your family? Yes No
If yes, please list _____

List any previous operations:

_____ Age _____ _____ Age _____
Any complications? _____

Social History

Have you ever smoked cigarettes? Yes No How Long? _____ Packs per day? _____
Do you still smoke? Yes No When did you start smoking? _____ When did you stop smoking? _____

Are you exposed to cigarette smoke? Yes No Mild Moderate Severe

Do you chew tobacco? Yes No If so, How long have you chewed tobacco? _____