

PATIENT INFORMATION

(please fill in all areas, if not applicable, please state that, we using Electronic Medical Records which requires you must fill out in it's entirety, Thank you)

Last Name First Name Middle Initial

Name you wish to be called by _____ Previous name _____

Date of Birth ___/___/___ Social Security ___ - ___ - ___ Status (circle one) S M D W

HEIGHT _____ WEIGHT _____ Driver's License # and State Issued _____

Address _____

City, State, Zip _____

Home Phone () _____ Cell Phone () _____

Work Phone () _____

Preferred Contact Number (circle one) Home Work Cell Email

Email address _____

Occupation _____ Employer _____

Manager's Name _____

Address _____ City, State, Zip _____

Is this a Worker's Comp injury? Y N Date of injury ___/___/___ Claim # _____

Spouse's Name/Parents Name _____

Phone number (____) _____ SSN ___ - ___ - ___ Date of birth ___/___/___

Address _____

City, Sate, Zip _____

Primary Insurance Company _____

Card Holder Name & Relationship to you _____

Policy Holder: Date of birth ___/___/___ Social Security ___/___/___

Policy Number _____ Group _____

Emergency Contact: _____ Relationship to you _____

Home number (____) _____ Work (____) _____ Cell (____) _____

Who may we thank for referring you to our office? _____

MEDICAL HISTORY

Last Name First Name Middle initial

Allergies to Medications? Yes No Which drug and what kind of reaction do you have?

Are you allergic to Latex? Yes No

List all current medications and doses you are taking on a regular basis

Name of medication	Dosage/Frequency
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Are you taking Vitamins or Blood Thinners? Yes No If yes, which kind?

Are you currently under the Care of a Physician? If so, name of physician, telephone number, and what for what reason

Primary Care Physician _____ Phone _____

Date of Last Physical Exam? _____

PAST MEDICAL HISTORY

CIRCLE ONE MEMBER?		WHICH FAMILY MEMBER?	CIRCLE ONE		WHICH FAMILY
Abnormal bleeding	self	_____	Heart Disease	self	_____
Anemia	self	_____	Heart Murmur	self	_____
Artificial Valves	self	_____	Hemophilia	self	_____
Artificial Bones/Joints	self	_____	Hepatitis Type: _____	self	_____
Asthma	self	_____	HIV/AIDS	self	_____
Blood Transfusion	self	_____	Kidney Problems	self	_____
Blood Pressure (High)	self	_____	Liver Disease	self	_____
Blood Pressure (Low)	self	_____	Malignant Hyperthermia	self	_____
Breast Cancer	self	_____	Mitral Valve Prolapse	self	_____
Cancer: Type _____	self	_____	Pace Maker	self	_____
Chest Pain/Tightness	self	_____	Psychiatric Problems	self	_____
Diabetes	self	_____	Seizures	self	_____
Difficulty Breathing	self	_____	Shingles	self	_____
Emphysema	self	_____	Skin Cancer	self	_____
Fainting	self	_____	Skin Disease	self	_____
Glaucoma	self	_____	Substance Abuse	self	_____
Headaches	self	_____	Tuberculosis	self	_____
Hearing Loss	self	_____	Veneral Disease	self	_____
Heart Attack	self	_____	von Willebrand	self	_____
Heart Disease	self	_____	Other	self	_____
Heart Murmur	self	_____			
Hemophilia	self	_____			
Hepatitis Type: _____	self	_____			

Please list all surgeries you have undergone (including all cosmetic procedures) and dates of surgery

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Anesthesia, please check any that applies to you experience with general or local anesthesia

- | | |
|-------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> No past anesthesia problems | <input type="checkbox"/> Anesthesia complications |
| <input type="checkbox"/> Never received general anesthesia | <input type="checkbox"/> Allergic reaction |
| <input type="checkbox"/> Difficult intubation | <input type="checkbox"/> Difficulty waking up |
| <input type="checkbox"/> Malignant hyperthermia Post-op N/V | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Local anesthetic complication | <input type="checkbox"/> Sensitivity to anesthetic agent |
| | <input type="checkbox"/> Vomiting |

Do you Smoke? (circle one) Yes or No

If yes, how much? _____

Do you consume Alcohol? (circle one) Yes or No

If yes, how often _____

Do you exercise? Yes No How often? _____

For Female Patients:

Yes No Do you have regular periods?

Yes No Are you going through menopause?

Yes No Are you pregnant or lactating?

Yes No During pregnancy, did you ever get hyperpigmentation or masking?

Yes No Are you currently on birth control?

Number of pregnancies? _____

Date of last breast exam? _____

Date of last Pap Smear? _____

Ability to Heal:

Yes No Does your skin appear fragile, burn easily?

Yes No Do you form thick or raised scarring from a cut or burn?

Yes No Do you wax or use depilatories on your face?

Yes No Do you ever get cold sores?

Patient Signature _____ Date _____