

PATIENT INFORMATION

Date: _____ Name: _____

Describe what brings you here: _____

Height: _____ Weight: _____ Family Physician: _____

DO YOU HAVE OR HAVE YOU HAD: (Circle – and give date of occurrence)

Stroke	No	Yes	HIV/AIDS	No	Yes
Diabetes	No	Yes	Hepatitis	No	Yes
Asthma	No	Yes	Eating Disorder	No	Yes
Respiratory Disorder	No	Yes	Stomach Ulcers	No	Yes
Kidney Disease	No	Yes	Heart Disease	No	Yes
High Blood Pressure	No	Yes	Any other condition or illness:	_____	
Psychiatric condition	No	Yes	_____		

Do you smoke?	No	Yes	How much? _____	How many years? _____
Do you drink alcohol or beer?	No	Yes	How Much? _____	

Have you or any blood relative had an adverse reaction to anesthesia? No _____ Yes _____

DO YOU KNOW OF ANY BLOOD RELATIVE WHO HAS OR HAD: (Circle and give relationship)

Diabetes	No	Yes	Excessive bleeding	No	Yes
High fever after surgery	No	Yes	Psychiatric condition	No	Yes
Heart Disease	No	Yes			

PLEASE WRITE IN THE NAMES AND DATES OF ANY OPERATIONS, ILLNESS, OR INJURIES WHICH YOU **HAVE** HAD: (Please include any cosmetic procedures)

<u>DATE</u>	<u>OPERATION OR HOSPITALIZATION?</u>
_____	_____
_____	_____
_____	_____

No Yes Have you ever bled excessively from a tooth extraction or laceration? _____

No Yes Do you take aspirin regularly? How often? _____

WOMAN ONLY

No Yes Do you still have regularly monthly menstrual periods?
 No Yes Have you had a mammogram? If yes, date of most recent _____.
 How many pregnancies: _____ How many live births: _____

DRUG ALLERGIES (Please List) _____

By signing I am affirming that I have answered all the questions above truthfully, and completely. I understand that withholding information from my Doctor or any other healthcare provider constitutes a risk to my health.

Patient Signature: _____

Reviewed on _____ by _____