

Name _____

Date of Birth ___/___/___

Today's Date ___/___/___

Male Female Height _____

Weight _____

Office Use Only

Temp _____

Reason for Visit _____

Prior Surgeries and Hospitalizations:

Current Medications:

Surgical Issues (check all that apply)

- Anesthesia problems (you or a close relative)
- Bleeding disorder or on a blood thinner
- Loose / removable dental work

- Pregnant / possibly pregnant
- Objection to blood transfusion
- Nausea following anesthesia

- Contact lenses
- Reflux or heartburn
- Sleep apnea

None

Comments: _____

Allergies (medications, LATEX or other): Please indicate the reaction (e.g. hives, rash, difficulty breathing) **No allergies**

Head and Neck

- Yes No Jaw pain (TMJ pain)
- Yes No Neck stiffness

Comments

Respiratory

- Yes No Smoker
- Yes No Shortness of breath

Cardiovascular

- Yes No High blood pressure
- Yes No Stroke
- Yes No Coronary artery disease (angina, prior heart attack)
- Yes No Congestive heart failure
- Yes No Irregular rhythm
- Yes No Heart murmur
- Yes No Peripheral vascular disease

Gastrointestinal/Renal

- Yes No Ulcers
- Yes No Liver problems
- Yes No Kidney failure

Musculoskeletal

- Yes No Arthritis
- Yes No Osteoporosis/osteopenia
- Yes No Artificial joints

Neurologic

- Yes No Seizures
- Yes No Paralysis

Metabolic

- Yes No Diabetes
- Yes No Thyroid disease

Infectious Disease

- Yes No HIV
- Yes No Hepatitis (B,C)
- Yes No MRSA (past or present)

Social

- Yes No Alcohol or recreational drugs

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Reviewed by MD

Sig _____
Date ___/___/___

Reviewed by MD

Sig _____
Date ___/___/___

Reviewed by patient

- No changes from prior
 - Changes noted
- Date ___/___/___

Reviewed by patient

- No changes from prior
 - Changes noted
- Date ___/___/___

Reviewed by patient

- No changes from prior
 - Changes noted
- Date ___/___/___

