PATIENT INFORMATION

NAME: _____ _____AGE: _____Date of Birth: _____
_____

Occupation: _____ ___Height: _____ Weight: _____Religion: ____
_____

Marital Status: _____ How Long: _____ Children: _____ Ages:
_____

Reason for Your Visit Today:
_____
_____
_____

MEDICAL PROBLEMS: (check where appropriate)
Diabetes ____ High Blood Pressure ____ Asthma ____ Heart Disease____ Lung Disease ____
Kidney Disease ____ Skin Disorders ____ Psychiatric Disorders ____ Liver Disease _____Bleeding Disorder____
Herpes ____ HIV ____ Mitral Valve Proplapse ____ Seizures ____ Stroke ____ Eye Problems____
Cancer ____ (please specify) _____
Other _____
If you checked any of the above, please explain your condition and treatment
_____
_____
_____

Do you have any allergies? _____ Please
specify_____

Please list any medications that you are currently taking (including over the counter):

_____
_____
_____
_____
_____
_____
_____
_____

Please list any previous operations. Please indicate approximate date next to the procedure.

_____ _____ _____
_____
Date Date
_____ _____ _____
_____
Date Date

Do you smoke? _____ __If yes, how long have you been smoking? _____ ___ How many per day? _____
Have you ever smoked? _____ If yes, how long? _____ How many per day? _____ When did you stop? _____

Last mammogram (if applicable) _____ Results _____ Bra Size_____

CURRENT PHYSICIAN/S:

PHYSICIAN ADDRESS PHONE
SPECIALITY

_____
_____
_____
_____
_____