

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Current Medications Taken: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Age: \_\_\_\_\_

Do you wear contact lenses? Y or No

Dentures, partial plates, loose teeth? Y or N

Date of last Physical Exam: \_\_\_\_\_ By Whom: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you use: Alcohol Y or N How often: \_\_\_\_\_  
Tobacco Y or N How often: \_\_\_\_\_  
Aspirin Y or N How often: \_\_\_\_\_  
Street Drugs Y or N How often: \_\_\_\_\_

Do you have bleeding problems? Y or N (Females only) Last menstrual period: \_\_\_\_\_

Does your religion prohibit blood transfusions? Y or N

Have you ever had difficulties with anesthesia? Y or N If yes, explain: \_\_\_\_\_

Any Medical Problems with:

If yes, please explain:

- Epilepsy/Seizures Y or N
- Headaches Y or N
- Eyes Y or N
- Diabetes Y or N
- Ears Y or N
- Nose Y or N
- Ulcers Y or N
- Thyroid Y or N
- Lungs Y or N
- Heart Y or N
- Blood Pressure Y or N
- Liver/Hepatitis Y or N
- Kidneys/Bladder Y or N
- Unusually Scars Y or N
- Other Y or N

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Have you ever had significant emotional problems? Y or N \_\_\_\_\_

Have you ever been under psychiatric care? Y or N \_\_\_\_\_

Any current medical conditions under treatment by a Physician? \_\_\_\_\_  
\_\_\_\_\_

Any previous surgeries or Hospital admissions? \_\_\_\_\_  
\_\_\_\_\_

Patient/or responsible party signature: \_\_\_\_\_