

DATE \_\_\_\_\_ MARRIED \_\_\_ WIDOWED \_\_\_ DIVORCED \_\_\_  
PATIENT'S NAME \_\_\_\_\_ SPOUSE'S NAME \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_ ZIP \_\_\_\_\_ BIRTH DATE \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_  
E-MAIL ADDRESS \_\_\_\_\_  
EMPLOYER & ADDRESS \_\_\_\_\_

**APPOINTMENTS CONFIRMED BY :** CELL PHONE \_\_\_\_\_  
E-MAIL HOME \_\_\_ E-MAIL BUSINESS \_\_\_ HOME PHONE \_\_\_\_\_  
BUSINESS PHONE \_\_\_\_\_

PHYSICIAN NAME \_\_\_\_\_ PHONE \_\_\_\_\_  
ARE YOU TAKING ANY MEDICATIONS (this includes all over the counter drugs as well as prescribed drugs and herbal medications)...YES \_\_\_ NO \_\_\_  
IF YES WHAT? \_\_\_\_\_

DO YOU HAVE ANY MEDICAL OR OTHER ALLERGIES? YES \_\_\_ NO \_\_\_  
IF YES, WHAT ARE THEY? \_\_\_\_\_

**ANY RECENT SERIOUS ILLNESS?** \_\_\_\_\_  
ARE YOU PREGNANT OR COULD YOU BE? YES \_\_\_ NO \_\_\_ MONTHS \_\_\_\_\_

ANY HISTORY OF:

HEART PROBLEMS	YES ___ NO _____
HIGH BLOOD PRESSURE	YES ___ NO _____
RHEUMATIC FEVER	YES ___ NO _____
KIDNEY OR LIVER DISEASE	YES ___ NO _____
GLAUCOMA	YES ___ NO _____
ALLERGIC TO ANESTHETIC	YES ___ NO _____
EMOTIONAL STRESS	YES ___ NO _____
PROLONGED BLEEDING	YES ___ NO _____
ASTHMA	YES ___ NO _____
EPILEPSY	YES ___ NO _____
ARTHRITIS	YES ___ NO _____
HEPATITIS           TYPE _____	YES ___ NO _____
DIABETES	YES ___ NO _____
ARTIFICIAL JOINTS	YES ___ NO _____
HEART VALVE PROBLEMS	YES ___ NO _____
H.I.V. POSITIVE	YES ___ NO _____

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_