History & Physical

NAME: ____

Acct #: ______________ DOB: _______________ Gender: __________________

DATE: ____________________

REASON FOR VISIT: ____

____

ALLERGIES: Penicillin _______ Local Anesthesia _______ Latex _______

Other(s) ____

Do you smoke cigarettes? _______ How many packs per day?__________

CURRENT MEDICATIONS: Aspirin _____ Oral Contraceptives _____ Blood Thinners _____

Name of Medication _______________________ Dosage ______________________

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Name of Medication _______________________ Dosage ______________________

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Name of Medication _______________________ Dosage ______________________

Name of Medication _______________________ Dosage ______________________

Continue on back of page if necessary

Are you currently under the care of or have you been treated by a Medical Physician for any significant illness other than colds, flu or virus? *Describe*_____________________

____

Physician Name ____

PAST SURGICAL HISTORY:

Date ________ Type ______________________________ Doctor ___________________

Date ________ Type ______________________________ Doctor ___________________

Date ________ Type ______________________________ Doctor ___________________

Date ________ Type ______________________________ Doctor ___________________

Date ________ Type ______________________________ Doctor ___________________

Date ________ Type ______________________________ Doctor ___________________

Patient Signature ___________________________