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 _____

Name of Medication _____ Dosage _____

Name of Medication _____ Dosage _____

Name of Medication _____ Dosage _____

Name of Medication _____ Dosage _____

Name of Medication _____ Dosage _____

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 _____