PATIENT HEALTH INFORMATION

NAME: _____ TODAY'S DATE: _____

HOME PHONE NUMBER: (_____) _____ DATE OF BIRTH: _____ AGE: _____

WORK PHONE NUMBER: (_____) _____ HEIGHT: _____ WEIGHT: _____

FAMILY DOCTOR/INTERNIST: _____

REASON FOR VISIT: _____

PAST MEDICAL HISTORY: (OTHER THAN SURGERY) _____

_____

_____

PAST SURGERIES WITH DATES: _____

_____

CURRENT MEDICATIONS: **INCLUDE DOSAGES AND INSTRUCTIONS FROM BOTTLE**
(PRESCRIPTION/OVER-THE-COUNTER/HERBAL/DIETARY SUPPLEMENTS):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

DO YOU TAKE (routinely): Aspirin/Baby Aspirin? Coumadin/Warfarin? Lovenox? Plavix?

ARE YOU DIABETIC: YES / NO **IF YES, DO YOU TAKE GLUCOPHAGE/METFORMIN? GLUCOVANCE?**

ALLERGIES TO MEDICATIONS: _____

OTHER ALLERGIES: _____
(HAVE YOU EVER HAD A REACTION TO ANY DYE STUDIES: YES / NO)
(HAVE YOU OR A FAMILY MEMBER HAD A REACTION TO GENERAL AND/OR LOCAL ANESTHESIA? YES / NO

USE OF:

ILLICIT DRUGS: YES / NO WHAT KIND _____ HOW LONG _____ HOW MUCH _____

ALCOHOL: YES / NO WHAT KIND _____ HOW LONG _____ HOW MUCH _____

TOBACCO: YES / NO WHAT KIND _____ HOW LONG _____ HOW MUCH _____

CAFFEINE: YES / NO WHAT KIND _____ HOW LONG _____ HOW MUCH _____

SOCIAL HISTORY: single married divorced widowed other _____ children: yes / no If yes, how many?: _____

OCCUPATION: _____

FAMILY HISTORY: Health status or cause of death of:

MOTHER: _____ FATHER: _____
SISTER(S): _____ BROTHER(S): _____
DAUGHTER(S): _____ SON(S): _____
OTHER: _____

ANY OTHER HEALTH PROBLEMS?: _____

_____

_____ Dr. Ballard _____ Dr. Bermas _____ Dr. Black _____ Dr. Cheng _____ Dr. Duppler
_____ Dr. Klingbeil _____ Dr. Krieger _____ Dr. Tretinyak _____ Dr. Vogt _____ Dr. Winek