We ask that you help us by filling out some basic information about yourself. Please fill out the below boxes as best you can. Circle the answer that applies to you. Please give detail on the line provided.

General History & Physical

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: Female Male

Who is your regular doctor: _____

Please describe the problem you are seeing the doctor for:

_____

_____

Were you referred by someone other than your regular doctor?: Yes No

If yes, who referred you? : _____

Medical History:
Have you had in the past or do you now have any of these health conditions? Please give a brief description if appropriate.

	Yes	No	Past	Current
Eye problems				
Ear, nose or throat problems				
Heart problems				
High blood pressure				
Lung problems				
Digestive problems				
Kidney or liver problems				
Ovary or uterine problems				
Arthritis or joint problems				
Skin changes or problems				
Seizures or headaches				
Depression or anxiety				
Thyroid disease				
Diabetes				
Stroke or TIA				
Sleep apnea				
Blood clots or easy bleeding				
Are you taking blood thinner?				
Cancer of any kind				
Other problems:				
Is there anything in your body that you weren't born with?				

DTM0022

Place Patient Label Here

Surgery | Date | Surgeon

Have you ever had problems with anesthesia?: Yes No

If Yes, please explain: _____

Family History (please include cancer, diabetes, heart disease, high blood pressure, stroke or other diseases):

Social History:

Tobacco Use Yes No If yes, packs per day _____ For how long? _____

If you have quite smoking when did you quit _____

Alcohol Use Yes No If yes, how much and how often do you drink? _____

Other Drug Use Yes No Please list: _____

What type of work do you do? _____

Do you have a Living Will? _____

A Power of Attorney for Healthcare? _____

Drug Allergies (please include reaction(s)): _____

Current Medications:

Name: Dose: How often?

Current Weight: _____ Current Height: _____