NAME _____

YOUR REASON FOR TODAYS VISIT_____
Duration of problem_____Date_____

WEIGHT_____
STREET_____ HEIGHT_____
CITY_____STATE_____ DATE OF BIRTH_____AGE_____
ZIP_____ REFERRED_____
EMAIL_____
_____

CELL PHONE_____ HOME PHONE_____
EMPLOYER_____ PRIMARY CARE DOCTOR_____
OCCUPATION_____ PHARMACY_____
WORK PHONE_____ INSURANCE_____
RACE_____ PREFERRED LANGUAGE_____

PREFERRED METHOD OF COMMUNICATION CELL HOME WORK EMAIL
SPOUSE OR PARENT NAME AND NUMBER_____

DRUG ALLERGIES REACTION SEVERITY
_____
FOOD ALLERGIES REACTION SEVERITY
_____
ENVIRONMENTAL REACTION SEVERITY
_____
LATEX ALLERGY YES/NO ALLERGY TO LOCAL ANESTHETIC YES/NO

CURRENT MEDICATION/HERBS/SUPPLEMENTS DOSE (USE BACK IF NEEDED)
_____
_____
_____
ONGOING MEDICAL PROBLEMS:_____

PLEASE CIRCLE IF YOU ARE EXPERIENCING ANY BELOW:
FEVER, CHILLS, WEIGHT LOSS, SORE EYES, DRY EYES, SORES IN MOUTH ,
CHEST PAIN. LEG PAIN, NAUSEA, DIARRHEA, BURNING URINATION, FREQUENT URINATION,
MUSCLE JOINT PAIN, NUMBNESS OF FEET, DIZZINESS,
FATIGUE, COLD INTOLERANCE, SWOLLEN LYMPH GLANDS, RUNNY NOSE,ASTHMA, HISTORY OF STD, HIV HISTORY OF DEPRESSION/ANXIETY

PAST SURGERIES_____

VACCINATIONS FLU YES/NO PNEUMONIA YES/NO SHINGLES YES/NO
DATE_____ DATE_____ DATE_____

ARTIFICIAL JOINT YES/NO MITRAL VALVE OR ARTIFICIAL HEART VALVE YES/NO
ANTIBIOTIC BEFORE DENTAL PROCEDURE YES/NO

ALCOHOL INTAKE PER WEEK_____ SMOKING HISTORY CURRENT/FORMER/NONE
FAMILY HEALTH HISTORY_____
CURRENTLY PREGNANT/NURSING YES/NO CURRENTLY HAVE A COLD YES/NO
RECENT FALLS YES/NO ARE YOU EXPERIENCING ANY PAIN YES/NO