PATIENT HISTORY / ASSESSMENT FORM

Please answer all questions to the best of your ability.

Practitioner: _____ Date: _____

Patient Name: _____ Date of Birth: _____ Sex: □ M □ F
Address: _____ Phone: (hm) _____ (wk) _____
City/State/Zip: _____ Referring Physician: _____
Current Employer: _____ Current Occupation: _____
Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated
Reason for visit today: _____

ALLERGIES: List any allergies you have to medications, foods, or environment _____
_____

Do you have a **LATEX** sensitivity or allergy? □ Yes □ No
Following a medical, surgical or dental procedure, have you ever had any unexplained itching, hives, swelling, or anaphylactic reaction? □ Yes □ No
Have you had symptoms such as sneezing, coughing, wheezing, rash or hives when handling rubber products, balloons, latex gloves or Band-Aid's? □ Yes □ No

CURRENT MEDICATIONS: Please list all current medication (and dosage, if known). Include over the counter drugs, herbal remedies, nutritional supplements, etc._____
_____
_____
_____

HISTORY: Please indicate if you have previously or are currently experiencing any of the following problems:

Condition	**Past Problem**	**Current Problem**	**Explain any current symptoms or treatment**
Anticoagulant therapy/ (blood thinners)	□Yes □ No	□ Yes □ No	_____
Arthritis	□Yes □ No	□ Yes □ No	_____
Asthma	□Yes □ No	□ Yes □ No	_____
Cancer	□Yes □ No	□ Yes □ No	_____
Diabetes	□Yes □ No	□ Yes □ No	_____
Heart trouble	□Yes □ No	□ Yes □ No	_____
High Blood pressure	□Yes □ No	□ Yes □ No	_____
Convulsions	□Yes □ No	□ Yes □ No	_____
Lung trouble	□Yes □ No	□ Yes □ No	_____
Acute infections	□Yes □ No	□ Yes □ No	_____
Thyroid trouble	□Yes □ No	□ Yes □ No	_____
Kidney trouble	□Yes □ No	□ Yes □ No	_____
Bleeding tendencies	□Yes □ No	□ Yes □ No	_____
Fatigue	□Yes □ No	□ Yes □ No	_____
Skin Rashes	□Yes □ No	□ Yes □ No	_____
Other	□Yes □ No	□ Yes □ No	_____
If yes, specify:	_____		_____

Past Surgeries, including date:_____
_____

Have you had any reaction to anesthesia? □ Yes □ No

Pt. Name: _____ Pt #:_____ DOB: _____