NEW PATIENT DATA BASE

Name ____________________________________ Birthdate__________________ Date________________

Weight: __________________

1. List any operations you have had and the approximate year (or age).

2. List all significant medical illnesses you have had and the approximate date.

3. List any medication you are now taking.

4. List any allergies to medication and the type of reaction.

Are you allergic to PENICILLIN? Yes_______ No ________

5. Have you or any blood relative had any difficulty with or reaction to general anesthesia?

6. Do you smoke? Yes______ No _______ How much? _________ How long? ___________

7. Do you use alcohol? Yes______ No_______ How much? __________

8. Do you drink coffee? _______ tea? _______ How much? _________

9. Do you have a family history of the following? If so, who?

Asthma ____________________________ Hayfever ______________________________________

Bleeding Disorder ____________________ Heart Disease __________________________________

Cancer ______________________________ High Blood Pressure ____________________________

Deafness ____________________________ Migraine ______________________________________

Diabetes ____________________________ Stroke ____

Eczema _____________________________ Tuberculosis ___________________________________

IF FURTHER EXPLANATION IS NECESSARY, PLEASE USE THE OPPOSITE SIDE.