Name of Patient:__________________________Age:________Ht:___Sex:__DOB:

	Yes	No
Are you presently in good health?	☐	☐
Past serious illnesses?	☐	☐
If yes, please explain		
Are you being treated for any illness?	☐	☐
If yes, please explain		
List all medications which you are taking:		
Allergies to medications?	☐	☐
If yes, please list		
Date of last physical exam		
Is there any chance that you are pregnant?	☐	☐
If yes, please explain		
Have you ever had a blood transfusion?	☐	☐
List all operations in the past		
Any reaction to Lidocaine?	☐	☐
Do you use tobacco products?	☐	☐
If yes, please list how much and for how long		
Have you seen other doctors for the problem which brings you here today?	☐	☐

If yes, please list____

DO YOU HAVE A PAST HISTORY OF

	Yes	No		Yes	No
Headaches	☐	☐	Reproductive Disorders	☐	☐
Glaucoma	☐	☐	Psychiatric Problems	☐	☐
High blood Pressure	☐	☐	Street Drugs	☐	☐
Bleeding Disorders	☐	☐	Emotional Problems	☐	☐
Heart Problems	☐	☐	Frequent Infections	☐	☐
Lung Problems	☐	☐	Bad Scarring	☐	☐
Hearing Problems	☐	☐	Thyroid Problems	☐	☐
Ulcers	☐	☐	Circulatory Problems	☐	☐
Snoring	☐	☐	Serious Injuries	☐	☐

Family History of: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Anesthetic Problems ☐ Asthma

Comments:____