MEDICAL HISTORY

Date _____

Name _____ Date of Birth _____

Please list any medications that you are currently taking:

MEDICATION NAME	DOSAGE & FREQUENCY (i.e. 5 mg once daily, etc)

Smoking Status (circle one):

Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Please list previous surgeries:

SURGERY	DATE / YEAR

For Office Use Only

Height _____ Weight _____ Blood Pressure _____ / _____

Pulse _____ Additional Information _____

_____