

**PATIENT INTAKE FORM**

DATE: \_\_\_/\_\_\_/\_\_\_ MALE \_\_\_ FEMALE \_\_\_

NAME: \_\_\_\_\_ D.O.B \_\_\_/\_\_\_/\_\_\_ AGE \_\_\_  
          First           M.I.           Last

REFERRING DOCTOR \_\_\_\_\_

REASON FOR THE VISIT \_\_\_\_\_

SYMPTOMS \_\_\_\_\_

PRESENT MEDICAL CONDITIONS \_\_\_\_\_

PAST MAJOR ILLNESSES OR OPERATIONS \_\_\_\_\_

MEDICATIONS NOW TAKING \_\_\_\_\_

\_\_\_\_\_

ALLERGIES \_\_\_\_\_

REACTIONS TO MEDICATIONS OR ANESTHESIA \_\_\_\_\_

ILLNESS IN FAMILY MEMBERS (HEART, CANCER, DIABETES, BLEEDING DISORDERS)

Father: \_\_\_\_\_ Mother: \_\_\_\_\_

Siblings: \_\_\_\_\_

Other Members: \_\_\_\_\_

Have any family members had an unusual reaction to anesthesia? \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EDUCATION \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ ALCOHOL PER WEEK \_\_\_\_\_

SMOKING PER WEEK \_\_\_\_\_ PAST HISTORY OF SMOKING? Y N

