PLEASE COMPLETE AND BRING WITH YOU TO YOUR APPOINTMENT

YOUR NAME: ______________________________________**EMAIL ADDRESS:**_________________________________

PROBLEM: ____

Description of symptoms: ____

____

Duration of symptoms: ____

What makes it worse? ____

What makes it better? ____

PLEASE CHECK ANY OTHER HEALTH PROBLEMS:

Heart Disorder ___ **Diabetes** ___ **Stroke** ___ **High Blood Pressure** ___ **Epilepsy** ___

Liver Problems ____ **Lung Problems/Asthma** ___ **Bleeding Disorder** ___ **Kidney Problems** ___

Anesthetic Reaction ___ **Other** ____

PAST SURGICAL HISTORY & DATES: ____

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PLEASE LIST ALL MEDICATIONS: Prescription, over the counter or alterative medicines and dosages if possible (please copy from the label on the bottle)____

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PLEASE LIST YOUR PHARMACY HERE: ____

ARE YOU ON BLOOD THINNERS? Aspirin? Warfarin? Other? Please list _____________________________________

If you are diabetic, are you on (please circle) Metformin (Glycon or Glucophage) Other ___________________________

LIST ALL ALLERGIES (in particular eggs, antibiotics, Valium, Demerol or Morphine ________________________________

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Have you ever been told by your physician to be on antibiotics prior to a procedure of dental work? ______________

DO YOU SMOKE OR VAPE? No ___ **Yes** ___ **If so, how much?** ____

Please be aware that we correspond by fax and at times need to request previous reports regarding the treatment of your current condition. Please sign below giving your authorization to request any required information. This will allow Plains Surgical Associates to aide in your care in accordance to the Privacy Act.

Please sign here ____ **Date:**_____________________________