NEW PATIENT INFORMATION

DATE: _____

Name _____ **HAND DOMINANCE:** _____ **AGE:** _____

DESCRIBE PROBLEM: _____

_____

_____

REFERRING PHYSICIAN: _____

NATURE OF EMPOLYMENT: _____

HOBBIES AND INTERESTS: _____

MEDICAL HISTORY

SIGNIFICANT MEDICAL CONDITIONS

_____

_____

PREVIOUS SURGERY/ PROBLEMS WITH GENERAL ANAESTHETIC:

_____

_____

LIST MEDICATIONS: _____

_____

_____

DO YOU SMOKE? IF YES. How much & how long?: _____

LIST ALLERGIES: _____

_____

	PROBLEMS:	**Description:**
_____	HEART CONDITIONS	_____
_____	RESPIRATORY (breathing)	_____
_____	KIDNEY	_____
_____	BLEEDING OR CLOTTING	_____
_____	DIABETES	_____