Patient Name _____ Date _____

MEDICAL HISTORY

Have you ever had?

_____ Cardiac Arrhythmias
_____ Angina
_____ Poor Circulation
_____ High Blood Pressure
_____ Rheumatic Fever
_____ Heart Attack
_____ If so Date _____
_____ Coronary Artery Disease
_____ Emphysema
_____ Tuberculosis
_____ Bronchitis
_____ Arthritis
_____ Other

_____ Asthma
_____ Problems Breathing
_____ Rheumatoid Arthritis
_____ Epilepsy/Seizures/Fainting Spells
_____ Liver Disease
_____ Kidney Disease
_____ Urinary Tract Problems
_____ Colon Related Problems
_____ Ulcers
_____ Cancer
_____ Thyroid Problems
_____ Gout
_____ Lupus

_____ Polio
_____ Anemia
_____ Tumors
_____ Hepatitis
_____ Meningitis
_____ Diabetes
_____ Adult
_____ Juvenile
_____ Eye Disease

Are you on?
Birth Control_____ Special Diet_____

Do you have loose, cracked, chipped, capped or false teeth? _____

Do you have a pacemaker? _____

Do you consume alcohol? _____

Do you smoke?_____ How much?_____

Do you experience excessive bleeding when you cut yourself? _____ Yes _____ No

Past Surgeries _____

_____

_____

Past Injuries _____

_____

Anesthesia Problems: _____ No _____ Yes

Family History (Including parents, grandparents, siblings, aunts, uncles) if applicable, who it affects.

_____ Arthritis _____
_____ Tuberculosis _____
_____ Cancer _____

_____ Diabetes _____
_____ Heart Disease _____
_____ Gout _____

Any other condition run in your family? _____

_____

_____

Has any of your family had problems with anesthesia? _____

What medications are you allergic to? _____

_____

Medicine Taking | Dosage/ How Often | Reason

_____

_____

_____

Patient Signature _____ Date _____

Physician Signature _____ Date Reviewed _____

DR SIMARD WORKSHEET FOR NEW PATIENT OR NEW PROBLEM

Name _____ Age _____ M___ F ___

Reason for today's visit _____
(What hurts/where)

Is your problem related to an accident? Y ___ N ___ Motor Vehicle Accident? Y __ N ___

Where did accident happen? _____ Date of Accident _____

Referring Physician _____ Family Physician _____

Is your problem/injury work related? Y ___ N ___ Present employer _____

Last day worked _____ Type of work _____

Does it involve: sitting _____ climbing _____ stooping _____ standing _____ lifting _____

Current Medications: _____

_____

DO NOT WRITE BELOW THIS PORTION OF THE PAGE

DIAGNOSIS:

Date _____
Consult Y ___ N ___
Initial Eval _____
W C _____
PO/recheck _____

ALLERGIES:

CHIEF COMPLAINT:

EXAM:

XRAY:

TREATMENT PLAN:

DR SIMARD FOLLOW UP VISITS

NAME: _____ DATE: _____

DIAGNOSIS:

WC ___
PO ___
Recheck ___

CHIEF COMPLAINT:

EXAM:

XRAY:

TREATMENT PLAN: