TRI-COUNTY surgical PARTNERS
DAVID A. STONE, DO

PATIENT HISTORY

IMPORTANT-Please answer all information, leaving no blanks. If item doesn't apply, put N/A. Thank you.

Patient Name: _____ Age: _____ Date: _____

Allergies: _____

	CIRCLE RESPONSE			CIRCLE RESPONSE	
Heart Attack	Yes	No	High Blood Pressure	Yes	No
Heart Disease	Yes	No	Diabetes	Yes	No
Lung Disease	Yes	No	Plavix or Coumadin	Yes	No
TB	Yes	No	Aspirin	Yes	No
Kidney Disease	Yes	No	Ibuprofen	Yes	No
Dialysis	Yes	No	Arthritis Pain Medicine	Yes	No
Liver Disease	Yes	No	Excess bleeding during prior surgery/dental care	Yes	No
Hepatitis	Yes	No	Require antibiotic prior to dental procedure	Yes	No

Serious Illnesses or Hospitalizations:

_____
_____

Surgeries:

_____
_____
_____

Family History of Cancer (Immediate Family):

_____
_____

Prescription Medicines:

_____
_____
_____
_____

Non-Prescription Medicines:

_____

Coffee: _____cups per day. Tea: _____cups per day. Cola: _____glasses/cans per day

Smoke: _____cigs/packs per day Chewing Tobacco: Yes_____ No_____

Patient Signature: _____ Date: _____

Guardian Signature (if required): _____Date:_____