Health Information Sheet:

Date: ___________________

Name: _____________________________________

Reason to be seen in the office today: ____

____

Allergies: ____

Medications: ____

____

Current Health Issues: ____

____

Previous Surgeries: ____

____

Smoking Status: ___ Nonsmoker ___ Smoker (amount per day: ________________________)

Family History of Cancer: ____

____

Do we have your approval to email you with questions about your medical history or upcoming surgery:

[ ] yes [ ] No

Email address: ____

Patient Signature: ____