Welcome To Our Office

Patient Name: _____ Date: _____

Did a Physician refer you? ☐ Yes ☐ No If yes, referring Physician name: _____

If referral is other than a Physician, please indicate: ☐ Friend ☐ Family ☐ Phonebook ☐ Internet ☐ Other: _____

List any family members seen by Dr. Ulrich: _____

Employer: _____ Occupation: _____

GENERAL MEDICAL INFORMATION:

Reason for today's appointment: _____

How long has this been a problem? _____

What prior treatment have you received for this problem? _____

_____ Height _____ Weight _____

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Do you smoke: ☐ Never ☐ Previously, but quit ☐ Currently, packs/day: _____

Chewing Tobacco: ☐ Never ☐ Previously, but quit ☐ Currently

Use of drugs: ☐ Never ☐ Previously ☐ Yes Type/frequency: _____

Excessive exposure at home or work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Noise ☐ N/A

ALLERGIES:

Do you have any allergies to medications: ☐ Yes ☐ No

If yes, please list: _____

Allergic to Latex? ☐ Yes ☐ No Allergic to X-Ray Dye? ☐ Yes ☐ No

MEDICATIONS: (list all medications you are currently taking)

Medication	Dose	Medication	Dose

PLEASE TURN PAGE OVER

MEDICAL HISTORY:

METABOLIC:
- Diabetes ☐ yes ☐ no
- Blood Clots ☐ yes ☐ no
- Bleeding Problems ☐ yes ☐ no
- Anemia ☐ yes ☐ no
- Thyroid Disorders ☐ yes ☐ no

HEART PROBLEMS:
- Myocardial infarction (Heart Attack) ☐ yes ☐ no
- Angina (Chest Pain) ☐ yes ☐ no
- Arrhythmia (Skipped Beats) ☐ yes ☐ no
- Heart Murmur ☐ yes ☐ no
- Mitral Valve Prolapse ☐ yes ☐ no
- High Blood Pressure (Hypertension) ☐ yes ☐ no

LUNG PROBLEMS:
- Emphysema / COPD ☐ yes ☐ no
- Tuberculosis (T.B.) ☐ yes ☐ no
- Asthma ☐ yes ☐ no
- Shortness of Breath ☐ yes ☐ no
- Snoring ☐ yes ☐ no

INFECTIOUS DISEASES:
- A.I.D.S. - H.I.V. ☐ yes ☐ no
- Hepatitis (Jaundice) ☐ yes ☐ no
- Infectious Mono ☐ yes ☐ no
  (When?_____)
- Meningitis ☐ yes ☐ no

NEUROLOGIC:
- Alterations in Vision (Glaucoma) ☐ yes ☐ no
- Seizures / Convulsions ☐ yes ☐ no
- Strokes / C.V.A. ☐ yes ☐ no

GASTROINTESTINAL / RENAL:
- Ulcers ☐ yes ☐ no
- Vomiting ☐ yes ☐ no
- Abdominal Pain ☐ yes ☐ no
- Kidney Disease ☐ yes ☐ no

CANCERS / TUMORS (please describe)

GENERAL:
- Glaucoma ☐ yes ☐ no
- Allergies ☐ yes ☐ no
- Sleep Apnea ☐ yes ☐ no
- Arthritis ☐ yes ☐ no

SURGICAL HISTORY: (please list any previous surgeries)

Have you or any family member had a reaction to any local or general anesthetic? ☐ yes ☐ no

FAMILY HISTORY: Does anyone in your immediate family have a history of any of the following? (Check ALL that apply)

- ☐ High Blood Pressure
- ☐ Lung Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Kidney or Liver Disease
- ☐ Stroke
- ☐ Bleeding Disorders
- ☐ Heart Disease
- ☐ Other: _____

HOSPITALIZATIONS:

PATIENT SIGNATURE: _____ DATE: _____

WE THANK YOU FOR YOUR ASSISTANCE IN THE EVALUATION OF YOUR HEALTH