HISTORY INTAKE FORM

NEW PATIENTS: How did you hear about Dr. Serra? Please check all that apply.

_____Google Search _____ Word of Mouth _____ Daily Sun Newspaper

_____Villages Magazine _____ Newcomers _____ Lake Style Magazine

_____ Movie Theater _____ Healthy Living Magazine

_____Yellow Pages Referred by _____

YOUR NAME_____ BIRTHDATE _____

Primary Care Doctor: _____

Smoker.....no yes amount per day _____ Alcohol use.....no yes type/amount per week _____

If former smoker, date quit _____ Weight _____ Height _____

Drug Allergies: _____

Novacaine/Lidocaine_____Epinephrine_____Iodine_____Shellfish_____Surgical Tape_____Latex_____

List previous surgeries or major illnesses and dates: If you have copy, we can scan.

_____ _____ _____

_____ _____ _____

List any medications you are taking INCLUDING PRESCRIPTION STRENGTH, non-prescription drugs, vitamins, herbals, blood thinners: If you have copy, we can scan.

_____ _____ _____

_____ _____ _____

Past Medical History:
Have you ever had the following?

Heart Disease.....no yes	Cancer.....no yes	Stomach Ulcer.....no yes
Arthritis.....no yes	Glaucoma.....no yes	Kidney Disease.....no yes
Rheumatic Fever.....no yes	Asthma.....no yes	Thyroid Disease.....no yes
Anemia.....no yes	Aids or HIV+.....no yes	Bleeding Tendency.....no yes
Tuberculosis.....no yes	Stroke.....no yes	Mitral Valve Prolapse....no yes
Diabetes.....no yes	Hepatitis.....no yes	High Blood Pressure.....no yes

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X_____ _____

Signature of patient or parent if minor. **Date**