EHR Patient Information

Name_____**Date**_____

Signature_____**Date of Birth**_____

Height_____**Weight**_____

Circle

Never Smoked, Former Smoker, Current Smoker: Everyday, Someday

Never Tobacco Chewer, Former Tobacco Chewer, Tobacco Chewer: Everyday, Someday

List All Surgeries with Dates:

_____

_____

_____

List Medications including Dosage:

_____

_____

_____

Allergic to any Medications:

_____

_____

_____