

GRAHAM M. KEMSLEY M.D. F.R.C.S.
ANDREW D. SMITH M.D.

DATE: _____

PATIENT NAME: _____

HOME PHONE: _____ CELL: _____ WORK: _____

First Middle Last Marital Status

OTHER CONTACT: _____ E-MAIL ADDRESS: _____

MAY WE INCLUDE YOU IN OUR E-MAIL LISTING? _____

YES **NO**

SSN #: _____ SEX: _____ DOB: _____ AGE: _____

Female Male

ADDRESS: _____

DRIVER'S LICENSE #: _____ (City, State, Zip Code)

EMPLOYER: _____

OCCUPATION: _____

WORK ADDRESS: _____

SPOUSE'S NAME: _____ WORK PHONE: _____

EMPLOYER: _____ OCCUPATION: _____

MEDICATIONS: List ALL medications you take, prescription AND over the counter medicines.

ALLERGIES: List ANY reactions you had to any medications you have taken.

PAST SURGICAL HISTORY:

OTHER MEDICAL PROBLEMS:

SOCIAL HISTORY:

Cigarette Smoker? _____ Packs per _____

Exercise Habits: _____

Alcohol: none occasional moderate frequent

Yes No

WHO REFERRED YOU: _____ MAY WE SEND A THANK YOU? _____

REASON FOR YOUR VISIT: _____

HOW SOON ARE YOU THINKING OF DOING THIS? _____

Have you seen another doctor about this procedure: _____

If yes, what happened with this doctor? _____

Will you need financing? _____

Yes No

May we call you following your visit: _____

Yes No

If yes, at which phone number? _____

May we send information to your home? _____

Yes No

PATIENT SIGNATURE: _____