



**Jon W. Ark, M.D. - Patient Information**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Doctor's name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Why are you seeing the doctor today? \_\_\_\_\_

How long have you had your symptoms? \_\_\_\_\_

Medications: Please list any medications or other supplements you are taking, include dose and frequency.

*Past Surgeries/Hospitalizations: Please list the type of surgery or the reason for hospitalization and the date.*

Family History: Please circle "yes" or "no" and indicate the relationship.

Diabetes    yes    no    \_\_\_\_\_      Blood Disorder                      yes    no    \_\_\_\_\_

Cancer      yes    no    \_\_\_\_\_      Anesthesia complication      yes    no    \_\_\_\_\_

Past Medical Problems: Please circle "yes" or "no" and give the details for "yes" responses.

Eyes                                      yes    no    \_\_\_\_\_

Ear, Nose, Throat                    yes    no    \_\_\_\_\_

Lungs/Breathing                      yes    no    \_\_\_\_\_

Heart                                      yes    no    \_\_\_\_\_

Digestive/GI                            yes    no    \_\_\_\_\_

Skin Diseases                          yes    no    \_\_\_\_\_

Numbness/Tingling                    yes    no    \_\_\_\_\_

Blood Disorder                        yes    no    \_\_\_\_\_

Immunologic Disorder                yes    no    \_\_\_\_\_

Musculoskeletal                        yes    no    \_\_\_\_\_

High Blood Pressure                  yes    no    \_\_\_\_\_

Cancer                                    yes    no    \_\_\_\_\_

Diabetes                                  yes    no    \_\_\_\_\_

Arthritis                                  yes    no    \_\_\_\_\_

Sleep Apnea                              yes    no    \_\_\_\_\_

Other                                      yes    no    \_\_\_\_\_

Allergies: Please list any drug allergies or undesirable reactions.

Do you smoke?    yes    no    Number of packs per day \_\_\_\_    Number of years \_\_\_\_

Do you drink alcohol?    yes    no    Number of drinks per day \_\_\_\_    per week \_\_\_\_

What is your height?    Feet \_\_\_\_    Inches \_\_\_\_      What is your weight?    Pounds \_\_\_\_

Are you right or left handed?    Right    Left    (please circle)