115 West Century Ave. Suite B Bismarck, ND 58503

Reason for today's visit: DO YOU NOW OR HAVE YOU EVER HAD	Patient: Date:	Age		Monital States	Waight	11	
DO YOU NOW OR HAVE YOU EVER HAD	1 9			iviaritai Status		Weight lbs	
Gaucoma or Eye Problems Yes Ye	Reason for today's visit:				Height ft		in
Gaucoma or Eye Problems Yes Ye	OO YOU NOW OR HAVE YOU EVER	S HAD	Vou mue	t circle an answer for each individ	lual item)		
Heart Attack Yes No Stroke Yes No Stroke Yes No Stroke Yes No Strokentsic Fever Yes No Storman Yes No Stating Y					iuai itciii)	Ves	No
Yellow Jaundice Yes No Flypertension Yes No Gallstones or Gallbladder Trouble Yes Yes No Chronic Cough Yes No No Chronic Cough Yes No Chronic Cough						Yes	No
Acholism or Gallbladder Trouble Yes No Callstones or Gallbladder Trouble Yes No Cancer, heart trouble Yes No Cancer Yes No Cancer, heart trouble Yes No Cancer,	 Stroke	Yes	No	*		Yes	No
Rheumatic Fever Yes No Chronic Cough Yes No Chronic Cough Yes No Chronic Cough Yes No Chronic Cough Yes No Chronic Software Set Breath Yes No No Chest Pain Yes No No					ouble		No
Chronic Cough						Yes	No
Chest Pain Yes No Asthma Yes No Coltits Yes No Problem Constitis Yes No Prought of Problems (Asthma Yes No Problem Constitution Yes No Problem Constitution Yes No Major Allergies Yes No Major Allergies Yes No Major Allergies Yes No Parlysis Yes No No Revrous Disorder Yes No Propositive Destructive Tendencies Yes No Problems Yes No P	Chronic Cough	Yes	No			Yes	No
Asthma Yes No Pronchitis Yes No Pronchitis Yes No Procuronia Yes No Diabetes Yes No Adjor Allergies Yes No Adjor Allergies Yes No Adjor Allergies Yes No Diabetes Yes No Diabetes Yes No Diabetes Yes Problem Constipation Yes Problem Constipation Yes Owniting Blood Yes Opital Diabetes Yes No Diabetes Yes		Yes	No	Ulcers		Yes	No
Bronchitis Yes No Problem Constipation Yes Yes No Unufuing Blood Yes Yes No Yes No Colier or Thyroid Disorders Yes Yes No Polary or Paralysis Yes No Polary or Polary or Polary or Paralysis Yes No Polary or Pol				Gastritis		Yes	No
Preumonia Yes No Ves No Ves No Goiter or Thyroid Disorders Yes No Goiter or Thyroid Disorders Yes Yes No Goiter or Thyroid Disorders Yes Yes No Diabetes Yes Yes No Diabetes Yes Yes No Skin Disorders Yes Yes No Skin Disorders Yes Yes Yes Yes No Arthritis Yes Yes							No
Goiter or Thyroid Disorders						Yes	No
Major Allergies							No
Palsy or Paralysis							No
Nervous Disorder Yes No Drug Habit Yes No Strig Habit Yes No Self- Destructive Tendencies Yes No Self- Destructive Tendencies Yes No Self- Destructive Tendencies Yes No Physical Education or Care Yes No Character Management of Poblems Yes No Character Management Yes No Percing of Problems Yes No Percing other than the ears Yes No Percing other than the ears Yes No Pentures, bridges, capped teeth or crowns Yes No Pentures, bri							No
Fracture of Neck or Spine	·						No No
Bleeding Tendency or Disorder Yes No Abnormal Bleeding after Tooth Extraction Yes Wes Abnormal Bleeding after Tooth Extraction Yes Wireld (Date of the Abnormal Bleeding after Tooth Extraction Yes Wes Abnormal Bleeding after Tooth Extraction Yes Wes Abnormal Bleeding after Tooth Extraction Yes Wes Wipper Wes No Blood Transfusion Yes Wes Wisper Yes No Blood Transfusion Yes Seizures or convulsions or fainting spells Yes Any family members with bleeding problems Yes Any family members with anesthesia problems Yes No Yes No Yes No Yes No Yes No Yes No							No
Abnormal Bleeding after Tooth Extraction Yes No Alirway, Obstruction (Nasal) Yes Airway, Obstruction (Nasal) Yes Airway, Obstruction (Nasal) Yes Airway, Obstruction (Nasal) Yes Seat Systs, Tumors, Abscesses Yes No Nipple Discharge (Apart from Normal Lactation) Yes Seat Systs, Tumors, Abscesses Yes No Nipple Discharge (Apart from Normal Lactation) Yes Seat Systs, Tumors, Abscesses Yes No Nipple Discharge (Apart from Normal Lactation) Yes Seat Systs, Tumors, Abscesses Yes No Nipple Discharge (Apart from Normal Lactation) Yes Seat Systs, Tumors, Abscesses Yes No Nipple Discharge (Apart from Normal Lactation) Yes Seat Systs, Tumors, Abscesses Yes No Nipple Discharge (Apart from Normal Lactation) Yes Seat Systs, Tumors, Abscesses Yes No Nipple Discharge (Apart from Normal Lactation) Yes Seat Systs, Tumors, Abscesses Yes No Nipple Discharge (Apart from Normal Lactation) Yes Seat Systs, Tumors, Abscesses Yes No Normal Please of Seat Systs, Tumors, Abscesses Yes No Nipple Discharge (Apart from Normal Lactation) Yes Seat Systs, Tumors, Abscesses Yes No Normal Please Iss All Present medications, including birth control pills, hormones, and vitamins, herbal medication, diuretics, w loss drugs. Include over-the-counter medications. Bo you have an allergic reaction to any medication? Yes No Which? Have you ever had any difficulties with any anesthesia? Yes No If yes, when and where? Do consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol? Yes No Amount: Are you pregnant? Yes No When was you last normal menstrual period? How many pregnancy? Births? Breast Fed? Yes No How long? How many pregnancy? Births? Breast Fed? Yes No How long? Have you ever been under psychiatric care? Yes No When? Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:	<u> </u>			•	ler		No
Airway Obstruction (Nasal) Yes No Ridney or Renal Disease Yes No Yes No Reart murmur Yes No Piercing other than the ears Yes No Piercing other than the ears Yes No Ridney Disorder Yes No Ridney Disorder Yes No Ridney Disorder Yes No Ridney Disorder Yes Ridney							No
Breast Cysts, Tumors, Abscesses Yes No Nipple Discharge (Apart from Normal Lactation) Yes Seizures or convulsions or fainting spells Yes Any family members with bleeding problems Yes Any family members with anesthesia problems Yes Any family members with anesthesia problems Yes Nipple Discharge (Apart from Normal Lactation) Yes Seizures or convulsions or fainting spells Yes Any family members with bleeding problems Yes Any family members with anesthesia problems Yes No Include over-the-counter medications, including birth control pills, hormones, and vitamins, herbal medication, diuretics, w loss drugs. Include over-the-counter medications. Birtha Pease No Which Yes No Which Yes No No No No No No No N					All Extraction		No
Nipple Discharge (Apart from Normal Lactation) Yes				E	sses		No
Piercing other than the ears Yes No Positive blood test for: HIV, AIDS, Hepatitis Yes No Eamily history of cancer, heart trouble, stroke Yes No Dentures, bridges, capped teeth or crowns Yes No 1. Have you ever seen another physician pertaining to reasons for todays visit? 2. Please list all present medications, including birth control pills, hormones, and vitamins, herbal medication, diuretics, w loss drugs. Include over-the-counter medications. 3. Do you have an allergic reaction to any medication?						Yes	No
Positive blood test for: HIV, AIDS, Hepatitis Yes No Eamily history of cancer, heart trouble, stroke Yes No Dentures, bridges, capped teeth or crowns Yes No Have you ever seen another physician pertaining to reasons for todays visit? Please list all present medications, including birth control pills, hormones, and vitamins, herbal medication, diuretics, w loss drugs. Include over-the-counter medications. Do you have an allergic reaction to any medication? Yes No Which? Have you ever had any difficulties with any anesthesia? Yes No If yes, when and where? Do consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol? Yes No Amount: Do you smoke? Yes No When was you last normal menstrual period? How many pregnancies? Births? Breast Fed? Yes No How long? Have you ever been under psychiatric care? Yes No When? Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:	Piercing other than the ears	Yes				Yes	No
Any family members with bleeding problems Yes Any family members with bleeding problems Yes Any family members with anesthesia problems Yes Any family members with anesthesia problems Yes I. Have you ever seen another physician pertaining to reasons for todays visit? Please list all present medications, including birth control pills, hormones, and vitamins, herbal medication, diuretics, w loss drugs. Include over-the-counter medications. 3. Do you have an allergic reaction to any medication? Yes No Which? 4. Have you ever had any difficulties with any anesthesia? Yes No If yes, when and where? 5. Do consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol? Yes No Amount: Do you smoke? Yes No When was you last normal menstrual period? How many pregnancies? Births? Breast Fed? Yes No How long? Who is your Primary Care Doctor: Have you ever been under psychiatric care? No When? Why? Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:	Positive blood test for: HIV, AIDS, Hep	atitis Yes	No	Blood Transfusion		Yes	No
Any family members with anesthesia problems Yes 1. Have you ever seen another physician pertaining to reasons for todays visit? 2. Please list all present medications, including birth control pills, hormones, and vitamins, herbal medication, diuretics, w loss drugs. Include over-the-counter medications. 3. Do you have an allergic reaction to any medication? Yes No Which? 4. Have you ever had any difficulties with any anesthesia? Yes No If yes, when and where? 5. Do consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol? Yes No Amount: Do you smoke? Yes No Amount: How many pregnant? Yes No When was you last normal menstrual period? How many pregnancies? Births? Breast Fed? Yes No How long? Who is your Primary Care Doctor: Have you ever been under psychiatric care? Yes No When? Why? Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:	Family history of cancer, heart trouble, s	stroke Yes	No			Yes	No
1. Have you ever seen another physician pertaining to reasons for todays visit? Please list all present medications, including birth control pills, hormones, and vitamins, herbal medication, diuretics, w loss drugs. Include over-the-counter medications. 3. Do you have an allergic reaction to any medication? Yes No Which? Have you ever had any difficulties with any anesthesia? Yes No If yes, when and where? Do consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol? Yes No Amount: Do you smoke? Yes No When was you last normal menstrual period? How many pregnancies? Births? Breast Fed? Yes No How long? Who is your Primary Care Doctor: Have you ever been under psychiatric care? Yes No When? Why? Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:	Dentures, bridges, capped teeth or crown	ns Yes	No			Yes	No
Please list all present medications, including birth control pills, hormones, and vitamins, herbal medication, diuretics, w loss drugs. Include over-the-counter medications. Do you have an allergic reaction to any medication? Yes No Which? Have you ever had any difficulties with any anesthesia? Yes No If yes, when and where? Do consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol? Yes No Amount: Are you pregnant? Yes No When was you last normal menstrual period? How many pregnancies? Births? Breast Fed? Yes No How long? Who is your Primary Care Doctor: Have you ever been under psychiatric care? No When? Why? Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:				Any family members with an	esthesia problems	Yes	No
Do consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?	2. Please list all present medicat loss drugs. Include over-the-co B. Do you have an allergic reaction Have you ever had any difficult.	ounter medication to any medications with any ane	ion? Ysthesia?	es No Which?	where?		
Who is your Primary Care Doctor:	Do consume regular amounts of Do you smoke? Yes No. Are you pregnant? Yes	f alcoholic bever o Amount: No When was	ages, inclu you last n	ormal menstrual period?	?	ount:	
 Have you ever been under psychiatric care? ☐ Yes ☐ No When?Why? Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons: 	3. Who is your Primary Care Doc	tor:			-		
	Have you ever been under psyc	hiatric care?	Yes \square N	When?W	/hy?		
Ry signing below. I agrees that the above information is complete and accurate to the best of my knowledge	10. Please list all hospitalizations a	nd surgeries, inc	luding pro	cedures done for cosmetic reason	s:		
below, I agreed that the above information is complete and accurate to the best of my knowledge.	By signing below, I agreee that the abo	ove information	is comple	ete and accurate to the best of n	ny knowledge.		