Affix Patient Label Here

Name:_____ Date of Birth:_____

Height:_____ Weight:_____ Left / Right Handed (please circle)

Reason for Consultation:_____

Primary Care Physician:

Name:_____ Phone:_____
Address:_____ Fax:_____
City:_____
State:_____ Zip:_____

Referred By:

Name:_____ Phone:_____
Address:_____ Fax:_____
City:_____
State:_____ Zip:_____

Smoking History:
- ❒ Never smoked
- ❒ Currently smoking _____ packs per day
- ❒ Quit less than 2 months ago, previously smoked _____packs per day
- ❒ Quit more than 2 months ago, previously smoked _____ packs per day
- ❒ Current using nicotine replacement therapy (patch, gum, etc.)

Alcohol Use:
- ❒ Yes – amount per week:_____
- ❒ No

Living Situation:
- ❒ Alone
- ❒ With adults
- ❒ With dependents

Marital Status:
- ❒ Single
- ❒ Domestic Partnership
- ❒ Married
- ❒ Separated
- ❒ Divorced
- ❒ Widowed

Number of Pregnancies:_____ Number of Children:_____