Norman J. Dozier, M.D., P.A.

Board Certified in Pain Management
Board Certified in Anesthesiology

Please Complete All Information

Today's Date _____

We need you to complete this form so we can update your information in our new Electronic Medical Record system. Thank you in advance for your help in our transition to this new system.

Patient's Name _____ Birthdate _____

Reason for your visit today: _____
(Where is your pain located today?)

Marital Status: Married Single Divorced Widowed

Sex: Male Female

Preferred Language: (Circle) English Spanish Deaf Other: Specify: _____

Ethnicity: (Circle) Hispanic or Latino Not Hispanic or Latino

Race: (Circle) White, American Indian, Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander,

Tobacco Use: (Circle) Do you smoke? Yes If yes, how much? _____

No If No, have you ever smoked? Yes No

Drug (medication) Allergies: _____

_____

Current medications: (or attach current list): _____
(Please include medications we prescribe for you also)

_____

_____

_____

_____

Office Use Only:

Weight: _____ B/P _____

Height: _____ Pulse: _____