Patient Assessment

Patient information

Name: G.Nani

Date of birth: Date	Gender: male

Occupation:	Mobile number:

Height:	Weight:	Race/ethnicity:

Reason for visit:

Social habits

Alcholo: ◯No ◯ Yes

Cocaine: ◯No ◯ Yes	Narcotics/drug use: ◯No ◯Yes

Smokes tobacco: ◯ No ◯Yes

If yes of years: of packs/days : Whenstopped:

cultural/religious beliefs that may affect care:

Do you prefer to learn by

☐ Seeing Tv,videos ☐ Hearing ☐ Doing

cultural/religious beliefs to learning

☐ Physical ☐ Emotional ☐ vision ☐ Financial ☐ Hearing

Medical history

Past medical history:	Current medical condition:	Relevant family medical history:

Allergies:	Current medication: