Patient Name: _____ Birth date: _____ Date: _____

Reason for today's visit: _____

Pharmacy Name and Location: _____

Medications (Include over-the-counter medications, vitamins and supplements)

Medication Name	Dosage

Allergies (drug, food, or environmental)

Allergic reaction to:	Reaction

Past Medical History (Please put an X in all that apply)

	Yes		Yes		Yes
Sleep Apnea		Migraine Headaches		DVT	
Kidney Disease		Seizures		Anemia	
Enlarged Prostate		Cancer		Asthma	
Inflammatory Bowel Disease		Thyroid Disease		COPD	
Fibromyalgia		Heart Attack		Pulmonary Embolism	
Parkinson's Disease		Heart Disease		Peptic Ulcer	
Disc Disease		Hyperlipidemia		Gallbladder/Biliary Disease	
Rheumatoid Arthritis		Heart Arrhythmias		GE Reflux	
Gout		Stroke or TIA		Liver/Hepatitis Disease	
Psychiatric or Behavioral Problems		Pacemaker Insertion		Diabetes	
Depression		High Blood Pressure			

Surgical History (Please put an X in all that apply)

	Yes		Yes
Shoulder Surgery		Craniotomy	
Elbow Surgery		Intrathecal Pump	
Hand/Wrist Surgery		Ventricular Shunt	
Hip Surgery		Spinal Cord Stimulator	
Knee Surgery		Thyroid Surgery	
Foot/Ankle Surgery		Appendectomy	
Spine Surgery		Cholecystectomy	
Pacemaker		Hysterectomy	
ICD		CABG	
Adverse Reaction to Anesthesia		Coronary Artery Stent	
Endarterectomy			

Family History

	Adverse Reaction to Anesthesia	Aneurysm	Asthma	Bleeding Disorder	Brain Tumor	Cancer, Other	Dementia	Diabetes	Heart Disease	Hypertension	Mental Illness	Migraine	Parkinson's Disease	Peptic Ulcer Disease	Seizures	Stroke	Tuberculosis	Vascular Malformations
Mother																		
Father																		
Maternal Grandmother																		
Maternal Grandfather																		
Paternal Grandmother																		
Paternal Grandfather																		
Sisters																		
Brothers																		
Other																		
Unknown/None																		

Social History

Use of Tobacco Products: ? Packs/Day: _____ Smokeless Tobacco: ?

Number of years: _____ Quit date: _____

Ready to quit: ?

Alcohol Use: ?

Number of drinks per week:

_____ Glasses of wine _____ Cans of Beer

_____ Shots of liquor _____ Drinks containing 0.5 oz of alcohol

Drug Use: ?

Per week: _____ Type: _____