Patient Name: DOB: Date:

Reason for today's visit:

PLEASE LIST ALL CURRENT PRESCRIPTION MEDICATIONS OR OVER THE COUNTER MEDICATIONS AND DOSAGES

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Are you allergic to any medications? ☐ Yes ☐ No List what medication(s):

Describe the type of allergic reaction you had to this medication:

Are there any medications which you stop taking in the past month ☐ Yes ☐ No

If you answered "yes", which medications have you stopped?

Are you currently taking Aspirin? ☐ Yes ☐ No How often?

PAST PATIENT HISTORY-Please list below ALL your past Operations, Hospitalizations, Illnesses/Inquiries

PLEASE BE SPECIFIC AS TO REASON AND DATES

Please list all past operations/hospitalizations with reason & date	Please list all personal illnesses/injuries and dates

PATIENT FAMILY HISTORY-PLEASE COMPLETE THE FOLLOWING TABLE

	Health Problems	If deceased, age and cause of death
Mother		
Father		
Siblings		

If surgery is planned, will you have help at home to assist in your recovery? ☐ Yes ☐ No

If no, what type of assistance do you feel that you may need?

Primary Care Physician Phone:

Referring Physician Phone:

Preferred Pharmacy: Phone:

PAST PATIENT HISTORY- PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR PAST

CONDITION	Yes	No	CONDITION	Yes	No
INFECTIOUS DISEASES			**ENDOCRINE**		
Hepatitis	☐	☐	Diabetes	☐	☐
HIV/AIDS	☐	☐	Thyroid Disease	☐	☐
Polio	☐	☐	**GASTROINTESTINAL**		
Rheumatic Fever	☐	☐	Stomach Ulcer	☐	☐
Tuberculosis	☐	☐	Gallstones	☐	☐
CARDIOVASCULAR			Liver Disease	☐	☐
High Cholesterol	☐	☐	**RENAL/GENITOURINARY**		
High Blood Pressure	☐	☐	Kidney Disease	☐	☐
Birth Defect of Heart	☐	☐	Kidney Stones	☐	☐
Heart Murmur	☐	☐	Prostate Problems	☐	☐
Pericarditis	☐	☐	Urinary Tract Infections	☐	☐
Heart Attack	☐	☐	**MUSCOLOSKELETAL**		
Previous Stent or Angioplasty	☐	☐	Gout	☐	☐
Irregular Heart Beats	☐	☐	Arthritis	☐	☐
Peripheral Vascular Disease	☐	☐	Back Pain	☐	☐
PULMONARY			Herniated Disc	☐	☐
Lung Disease	☐	☐	**HEMATOLOGIC/ONCOLOGY**		
Prior Pneumonia	☐	☐	Anemia	☐	☐
EXP. To inhaling hazardous agent	☐	☐	Cancer-List Type	☐	☐
NEUROLOGIC			Bleeding Problems	☐	☐
Stroke/TIA	☐	☐	Blood Clots	☐	☐
Migraines	☐	☐			
Seizure Disorder	☐	☐			