

### Patient Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Allergies to Medications \_\_\_\_\_

Environmental or Food Allergies \_\_\_\_\_

Routine Medications And Dosages \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Medications Taken In Last Month \_\_\_\_\_

\_\_\_\_\_

List All Past **Surgeries** (type and approximate year) \_\_\_\_\_

\_\_\_\_\_

**Past and Current Medical History** (check all that apply)

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> diabetes             | <input type="checkbox"/> asthma            | <input type="checkbox"/> GERD (acid reflux)  |
| <input type="checkbox"/> HIV                 | <input type="checkbox"/> thyroid problems     | <input type="checkbox"/> bleeding problems | <input type="checkbox"/> cancer              |
| <input type="checkbox"/> heart attack        | <input type="checkbox"/> other heart problems | <input type="checkbox"/> COPD/emphysema    | <input type="checkbox"/> other lung problems |
| <input type="checkbox"/> stroke              | <input type="checkbox"/> migraines            | <input type="checkbox"/> hepatitis         | <input type="checkbox"/> kidney problems     |
| <input type="checkbox"/> other _____         |   |  |  |

**Family History** (check all that apply)

- |                                       |                                      |  |  |                                 |
|---------------------------------------|--------------------------------------|--|--|---------------------------------|
| <input type="checkbox"/> hearing loss | <input type="checkbox"/> allergies   | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> cancer |
| <input type="checkbox"/> migraines    | <input type="checkbox"/> other _____ |  |  |                                 |

**Social History**

- |                                     |                              |                             |  |
|-------------------------------------|------------------------------|-----------------------------|--|
| Have you ever smoked tobacco?       | <input type="checkbox"/> yes | <input type="checkbox"/> no | if yes, ____ packs/day for ____ years      |
| Have you quit?                      | <input type="checkbox"/> yes | <input type="checkbox"/> no | if yes, how long ago? _____                |
| Have you ever used chewing tobacco? | <input type="checkbox"/> yes | <input type="checkbox"/> no |  |
| Do you drink alcohol?               | <input type="checkbox"/> yes | <input type="checkbox"/> no | if yes, ____ drinks per day / week / month |