DATE:	DATE OF BIRTH:	
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:

Preferred Pharmacy & Location

SOCIAL HISTORY:

TOBACCO USE:	Current	Former	Never
ALCOHOL USE:	Current	Non-Drinker	
SEXUALLY ACTIVE:	Yes	No	

DATE OF LAST MAMMOGRAM:	
DATE OF LAST FLU SHOT:	
DATE OF LAST PNEUMOVAX SHOT:	

ALLERGIES:

DRUG ALLERGIES:	REACTION

MEDICATIONS:

Medication Name/ OTC Name	Dosage	How often

DATE:	DATE OF BIRTH:	
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:

PAST MEDICAL HISTORY

Allergies	Yes/ No	Headaches	Yes/ No	Malignant hyperthermia	Yes/ No
Arthritis	Yes/ No	Hearing loss	Yes/ No	MRSA	Yes/ No
Asthma	Yes/ No	Heart disease	Yes/ No	Otitis media	Yes/ No
Cancer	Yes/ No	Hepatitis	Yes/ No	Rashes/Skin Problem	Yes/ No
Chronic lung disease	Yes/ No	HIV/AIDS	Yes/ No	Seizures	Yes/ No
Clotting disorder	Yes/ No	Hypertension	Yes/ No	Strep throat (recurrent)	Yes/ No
Diabetes	Yes/ No	Other:		Other:	
Other:		Other:		Other:	

PAST SURGICAL HISTORY

Adenoidectomy	Yes/ No	Cholecystectomy	Yes/ No	Sinus Surgery	Yes/ No
Airway Surgery	Yes/ No	Colonoscopy	Yes/ No	Tonsillectomy	Yes/ No
Appendectomy	Yes/ No	Esophagus surgery	Yes/ No	Ear tubes	Yes/ No
Bronchoscopy	Yes/ No	Hysterectomy	Yes/ No	Other:	
Other:		Other:		Other:	

FAMILY HISTORY

Cancer	Yes/ No	If yes, who?
Diabetes	Yes/ No	If yes, who?
Hypertension	Yes/ No	If yes, who?
Bleeding disorders	Yes/ No	If yes, who?
Reaction to anesthesia	Yes/ No	If yes, who?
Malignant hyperthermia	Yes/ No	If yes, who?

HOME SAFETY

Are there guns in the home?	Yes/No