Patient Name: ______________________________ **Date**: ____________

Referring Physician: ______________________________ **DOB**: ____________

Other Physicians or Specialists: ______________________________

1) **Please list ALL MEDICATIONS: (including over-the-counter) <u>EVEN IF YOU THINK WE HAVE THEM</u> that you are currently taking and the reason you are taking them**:
2) ☐ Check this box if NONE or fill in below

Drug:	**Dose:**	**Times A Day**	**Reason you take it**:

3) **PAST MEDICAL HISTORY**: (please check all that apply)
☐ HEART DISEASE ☐ ASTHMA ☐ DIABETES ☐ COPD ☐ HEPATITIS ☐ STROKE
☐ BLEEDING DISORDER ☐ HIGH BLOOD PRESSURE
Please list any other conditions: ______________________________

4) **PAST SURGICAL HISTORY**: (please list any surgeries that you have ever had)
☐ Check this box if NONE or fill in below

Surgery	**Year**	**Comments**

Any on-going or past treatments such as Chemo, radiation, IV treatments/infusions, allergy shots or allergy drops?______________________________

5) **OCCUPATIONAL HISTORY**:
____

6) **IMPLANTS:** ______________________________
(Examples: pacemaker, wires, screws or hardware, artificial joints)

DATE UPDATED: ____________ **REVIEWED BY**: ______________________________

☐**BJB** ☐**LVC** ☐**PBS** ☐**CFA** ☐**DPN** ☐**GA(B)P** ☐ **RRM** ☐**NP** ☐**RF** ☐**HB**

Pharmacy Name: ____
Address: ____**Phone #**_____________________

7) **SOCIAL HISTORY**: do you ever drink alcohol? Y/N occasionally weekly daily
   a. Do you smoke? Y/N
   b. Have you ever smoked? Y/N   If so, how long? ___________________
   c. Have you been environmentally (second-hand smoke) exposed to tobacco smoke? Y/N
   d. Have you ever been exposed to tobacco smoke during your perinatal period or during your Mother's pregnancy with you? Y/N
   e. Have you ever been exposed to occupational (at work) tobacco smoke? Y/N
   f. Have you ever used any other tobacco products? (please indicate type of tobacco, please include use of e-cigarettes) How long? ____

7) **FAMILY HISTORY**: HEART DISEASE ASTHMA DIABETES COPD HEPATITIS
 STROKE BLEEDING DISORDER HIGH BLOOD PRESSURE
 CANCER- LOCATION: ____
Please list any illnesses in the family: ____
____

Disease	Family Member	Comments

8) **ALLERGIES**: Check this box if NONE or fill in below
1. **LATEX ALLERGY: YES OR NO**
2. **PENICILLIN Reaction:** ____
 SULFA Reaction: ____
 ERYTHROMYCIN Reaction: ____
 CODEINE Reaction: ____
3. **Please list any other allergies and the reaction you have had:** ______________________________
____

9) **PLEASE SIGN HERE**:
The above responses are accurate to the best of my knowledge: _________________________________
(**Patient-18 years of age or older, if under age parent or guardian signature**)

____
(**Date**)

If you are not the patient, please print your name: ____

And relationship to patient: ____

PLEASE DO NOT WRITE BELOW THIS LINE

DATE UPDATED: _________________________ **REVIEWED BY**: ____
BJB **LVC** **PBS** **CFA** **DPN** **GA(B)P** **RRM** **NP** **RF** **HB**