**Surgical Associates of North Texas**

**Patient Name:** _____ **Date of Birth:** _____/_____/_____

**Allergies-** List all allergies to medications/foods/substances

_____ _____
_____ _____
_____ _____

**Medications-** List all medications/vitamins/supplements you are currently taking

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

**Operations and Hospitalizations-** List all operations and hospitalizations, if applicable

_____ _____
_____ _____
_____ _____

**Family History-** List any other relevant family history (i.e. hypertension, diabetes, heart disease, etc.)

_____ _____
_____ _____
_____ _____

**Social History-** Check which substances you use and describe how often you use them per day

( ) Caffeine:_____
( ) Tobacco: _____
( ) Alcohol:_____
( ) Illicit Drugs:_____

**Pharmacy Name:**_____ **Phone Number:**_____

*Your post-operative oral medications will be called into your local pharmacy a couple days prior to your surgery. We may also submit your information to a Compound Pharmacy if we think a pain cream may help with your post-operative pain. The Compound Pharmacy may contact you with information on the cream and confirm your interest in getting a pain cream.

**I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.**

Patient Signature:_____ Today's Date:_____