Name: DOB: Date:

Past Medical History

List ALL operations

Operation	Date	Doctor	Hospital

List ALL other hospitalizations:

Illness	Date	Doctor	Hospital

List ALL other serious illnessess or injuries:

Illness	Date	Doctor	Hospital

List any ongoing medical conditions for which you currently take medication:

Family History

Family Member	Illness

Social History

Occupation: _____

Marital status: _____

Do you use tobacco? never/current/former

If yes, please list age started, stopped, type of tobacco and amount per day

_____

Do you drink alcohol? yes/no/former

If yes or former, please list what type and how often

_____

Do you use caffeine? yes/no

If yes, please list what type and amount per day

_____

Medications

List all medications you are taking now and their dosages including all over the counter medications, vitamins and supplements

Medication	Dose	Instructions

Allergies

List medicines to which you are allergic and the type of reaction

Medication	Reaction