Patient: _____

Pharmacy: _____ #: _____ □ 90 day

Medications (List all current medications):

Medication	Dosage	Instructions	Allergies	Reaction

Past Medical History (Include previous surgeries, fractures, major illness or childhood diseases) + year

Pregnancy History:

Year of Birth	Sex	Delivery type	Complications (if any)

Social History (check the substances you use and describe how much you use):

	Caffeine	Cups? _____ Ounces (like 12oz or 20oz)? _____ Liters? _____ Per: Day/Week
	Tobacco	Dip? Cans/day: Cigarettes: # ea. or Pack/day How long? Quit when?
	Alcohol	#Drinks per Day_____ Week _____ or social drinker? _____ How long? Quit When?
	Other	

Family Health:

	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Family History (List any illnesses that run in your family):

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: _____ Date: _____

Physician: _____ Reviewed Date: _____