

Name: \_\_\_\_\_ Date of Visit: \_\_\_\_\_ DOB: \_\_\_\_\_

Who were you referred by: \_\_\_\_\_

<b>Medications;</b> including prescriptions, anti-inflammatory drugs or non-prescription medications			
MED: _____	DOSAGE: _____	MED: _____	DOSAGE: _____
MED: _____	DOSAGE: _____	MED: _____	DOSAGE: _____
MED: _____	DOSAGE: _____	MED: _____	DOSAGE: _____

<b>PHARMACY NAME:</b> _____	<b>PHARMACY CITY/STATE:</b> _____
-----------------------------	-----------------------------------

**DRUG ALLERGIES:**  no  yes If yes, please list; \_\_\_\_\_

**LATEX ALLERGY:**  no  yes

**Surgical History:** Please list any operations, including plastic surgery, you have undergone along with the dates:

\_\_\_\_\_

\_\_\_\_\_

**Hospital Admissions within the last year:** Please list any hospital admissions and reason(s) for admissions:

\_\_\_\_\_

**Current or Past Medical History:**

Oxygen Dependent	<input type="checkbox"/> no <input type="checkbox"/> yes	High Blood Pressure	<input type="checkbox"/> no <input type="checkbox"/> yes	Neurological Disease	<input type="checkbox"/> no <input type="checkbox"/> yes
History of COPD	<input type="checkbox"/> no <input type="checkbox"/> yes	Diabetes	<input type="checkbox"/> no <input type="checkbox"/> yes	Auto Immune Disease	<input type="checkbox"/> no <input type="checkbox"/> yes
Anticoagulants	<input type="checkbox"/> no <input type="checkbox"/> yes	Chronic Infections	<input type="checkbox"/> no <input type="checkbox"/> yes	Malignant Melanoma	<input type="checkbox"/> no <input type="checkbox"/> yes
Pacemaker	<input type="checkbox"/> no <input type="checkbox"/> yes	Communicable Disease	<input type="checkbox"/> no <input type="checkbox"/> yes	Other: _____	

**History of Heart Attack, Stroke, Stents, Pacemaker:** no yes

**Bleeding Problems; Excess Bleeding, DVT, Pulmonary Embolism, or Other Bleeding Disorders:** no yes

**Do you, or does anyone in your family, have a history of malignant hyperthermia?** no yes unknown

**Smoking:**  current tobacco user  former tobacco user  never tobacco user

**Vaping:** no yes **If yes, please check one:**  with nicotine  without nicotine

**Alcohol:** no yes **If yes, please circle one:** socially frequently history of alcoholism

**Do you have 3 or more alcohol drinks per day:** no yes

**Do you use a marijuana card:** no yes **Use any illegal drugs:** no yes **History of drug abuse:** no yes

**Do you have an Advanced Care Plan:** no yes **Name of surrogate decision maker:** \_\_\_\_\_  
**Relationship:** \_\_\_\_\_

**Are you up to date on your Covid-19 vaccine:** no yes

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Females:** Date of last mammogram \_\_\_\_\_ **Facility** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_