

Name: _____ Date of Visit: _____ DOB: _____

Who were you referred by: _____

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

PHARMACY NAME: _____	PHARMACY CITY/STATE: _____
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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: _____

Height: _____ **Weight:** _____ **Age:** _____

Females: Date of last mammogram _____ **Facility** _____

Patient's Signature: _____ **Date:** _____