Do you currently use tobacco products ___Yes __ No If yes, what type of tobacco? _____ How long? _____

Drug Allergies: _____

Medications: _____

PATIENT PAST MEDICAL HISTORY	YES	NO
Hay Fever, Asthma, Sinus		
Cancer		
Diabetes		
Heart Disease, Lung Disease		
Liver Disease, Hepatitis		
High Blood Pressure		
Kidney Disease		
Skin Cancer		
Skin Disorders		
Thyroid Disease		
Tuberculosis		
Stomach Ulcers		
Are You Pregnant		
Anemia		
Chemotherapy		
HIV		
Anesthesia Allergies		

Past Surgeries/Hospitalizations (Within Past 5 Years)

DATE AND TIME OF SURGERY	ANESTHESIA COMPLICATIONS - Y/N	DETAILS

FAMILY HISTORY	YES	AFFECTED FAMILY MEMBER
No Relevant Family History		
Unknown – Adopted		
Autoimmune Disorders		
Colon Cancer		
Diabetes		
Glaucoma		
High Blood Pressure		
High Cholesterol		
Liver Disease		
Lung Disease		
Malignant Melanoma		
Obesity		
Premature Coronary Heart Disease		
Skin Cancer		
Thyroid Disease		

E-Mail Address: _____

PHARMACY OF CHOICE: _____