

Patient Information

Today's Date _____

Name _____ Birthdate _____

Medical Clinic Name _____

Pharmacy Name _____

Please circle/list any allergies:

Aspirin Codeine Erythromycin Penicillin Sulfa Latex Hay Fever

Other: _____

Please list medications you are currently taking:

Please list serious illnesses, injuries, or surgeries you had **within the last 5 years:**

Have you taken or are you currently taking bisphosphonates?

(example: Fosamax, Boniva, Actonel).....Y/N

Are you using oral contraceptives?.....Y/N

Do you smoke or chew tobacco?.....Y/N

SEE REVERSE SIDE

Circle any of the following which you have had:

Anemia	Acid Reflux	Diabetes (1 or 2)	Aspergers Syndrome
Angina	Stomach Ulcers	Insulin Dep. Diabetes	Autism
Artificial Heart Valve		Thyroid problem	Cerebral Palsy
Blood Disease	AIDS	Cirrhosis	Dizzy Spells/Fainting
Congenital Heart Def	Arthritis	Hepatitis A /B /C	Epilepsy or Seizures
Heart Attack	Rheumatoid Arthritis	Jaundice	Intellectual Disability
Date_____			
Heart Condition	Cancer, list type	Kidney Disease	Anxiety
Heart Murmur	_____	Dialysis	Depression
Heart Surgery	Chemotherapy	Liver Disease	Nervous Disorder
Hemophilia	Radiation	Asthma	Pregnant
High Blood Pressure	Herpes	Bronchitis	Due Date_____
High Cholesterol	HIV Positive	COPD	
Irregular Heart Beat	HPV	Emphysema	Artificial Joints
			Date _____
Leukemia	Scarlet Fever	Mouth Breathing	Osteoporosis
Mitral Valve Prolapse		Respiratory Problems	
Pacemaker		Sinus Problems	Glaucoma
Rheumatic Fever		Sleep Apnea	Lupus (SLE)
Stents		Tuberculosis	Parkinson's Disease
Stroke, If so, when?		Use Inhaler	Alzheimers Disease
_____			Drug/Alcohol Abuse
			MRSA

I verify all medical information provided (above) is accurate:

Signature _____