

First Name: _____ Last Name: _____ MI: _____

Date of Birth: _____ Height: _____ Weight: _____

Family Physician _____ Referring Physician _____

Pharmacy Preference (include location) _____

ANY MEDICAL CONDITION NOT LISTED ON BUBBLE SHEET: _____

REASON FOR TODAY'S VISIT _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? () Yes () No

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. (Please include BLOOD THINNERS, SUPPLEMENTS, VITAMINS, AND OVER-THE-COUNTER MEDICATIONS)

ARE YOU CURRENTLY TAKING ALLERGY INJECTIONS? () Yes () No

ARE YOU NOW USING A CPAP MACHINE? () Yes () No

ARE YOU ALLERGIC TO ANY MEDICATIONS? () Yes () No **If yes, please list below:**

Name of Medication	Type of Reaction (Ex. Rash, Nausea, Vomiting, Other)

SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? () Yes () No

If yes, please list types of problems _____

List any surgeries you have had _____

Have you been hospitalized in the last three months? () Yes () No

If yes, list reason: _____