CURRENT DATE: _____ _____ _____ _____ _____

NAME: **DATE OF BIRTH:** _____

FAMILY DOCTOR: **ACCT:**

CURRENT MEDICATIONS & DOSAGE		PREVIOUS MEDICAL PROBLEMS & DATE
DRUG ALLERGIES		
		FAMILY HISTORY OF SERIOUS ILLNESS
PREVIOUS SURGERIES & DATE		
		HABITS
		DO YOU SMOKE?
		IF YES, HOW MUCH?
		DO YOU USE ALCOHOL?
		IF YES, HOW MUCH?
		DRUG USE?
		IF YES, WHAT?