Patient's Name: Preferred Pharmacy: Pharmacy Location:		Date of Birth:		
		Mail-away Pharmacy:		
_	Allergies allergic to any medications?	YES (please list below the medication and your reaction)		
	ATION What was your re	eaction?		
<u>-</u>				
_				
Family condition Please check	History (<u>not</u> your personal hists. If a family member died from this condition, Condition	story): Please mark if any one in your family has had any of the following in, please record in the Comment field which family member and his/her age at death. Comment Please enter any details that may be pertinent. If a family member died because of the condition, please enter the family member and		
		age that he/she died.		
	Allergies			
	Asthma			
	Autoimmune disease			
	CAD (Coronary Artery Disease)			
	Cancer			
	Cleft lip/palate			
	CVA (stroke)			
	Depression			
	Developmental Delay			
	Diabetes			
	GERD			
	Hearing disorder			
	Hematological disorder			
	Hyperlipidemia			
	Hypertension (High Blood Pressure)			
	Migraines			
	Obesity			
	Chronic Otitis Media			
	Otosclerosis			
	Renal disease			
	Seizure disorder			
	Sickle cell disease			
	Sleep apnea			
	Thyroid disorder			
	Complications related to anesthesia			

Arthritis CVA High cholesterol Otosclerosis Asthma Depression Hypertension Seasonal Allergi	<u>Adult Patients only—So</u>	cial History		
Please check your Marital Status: single married life partner separated divorced widowed Tobacco Use: Current Former Never Alcohol Use: No Yes Former If you marked current or former, please fill out below: If you marked yes or former, please fill out below: Type Daily Amount Frequency Last Drink Pediatric Patients only—Social History The pediatric patients resides with Who has legal custody of the pediatric patient? Does anyone in the home smoke? NO YES if so, for how many days per week? Patient's Past Medical History: Please mark if you have or have had any of the following. If you have condition not listed, please enter in the blanks provided. Anemia COPD Headaches Migraines Anxiety Coronary artery disease Heart disease Multinodular go Arthritis CVA High cholesterol Otosclerosis Birth disorder Diabetes Hyperthyroidism Seizure disorder Bleeding disorder Emphysema Hypothyroidism Steep disorder Concers GERD Intestinal disorder Stomach ulcer Conceptive heart failure Grave's disease Kidney disorder Vertigo Patient's Past Surgical History: Please list any surgeries you have had and the approximate date.	Occupation:			
Former Never Alcohol Use: No Yes Former f you marked current or former, please fill out below: Type Daily Amount Type Does anyone in the home smoke? NO YES Does anyone in the home smoke? NO YES if so, for how many days per week? Patient's Past Medical History: Please mark if you have or have had any of the following. If you have condition not listed, please enter in the blanks provided. Anemia COPD Headaches Migraines Anxiety Coronary artery disease Heart disease Multinodular go Arthritis CVA High cholesterol Doselerosis Asthma Depression Hypertension Seasonal Allergi Birth disorder Diabetes Hyperthyroidism Seizure disorder Cancer GERD Intestinal disorder Stomach ulcer Chronic infection ENT Syndromes Ifregular heart rate Tinnitus Congestive heart failure Grave's disease Kidney disorder Vertigo Complications related to anesthesia Patient's Past Surgical History: Please list any surgeries you have had and the approximate date.	'lease check your employme	nt status: FT PT	unemployed retired	disabled
f you marked current or former, please fill out below: Type	lease check your Marital St	atus: single married	life partner separated	divorced widowed
Type Daily Amount Units per Day Frequency Last Drink Pediatric Patients only—Social History The pediatric patients resides with Who has legal custody of the pediatric patient? Does anyone in the home smoke? NO YES Does the pediatric patient attend daycare? NO YES if so, for how many days per week? Patient's Past Medical History: Please mark if you have or have had any of the following. If you have or district on not listed, please enter in the blanks provided. Anemia COPD Headaches Migraines Anxiety Coronary artery disease Heart disease Multinodular go Arthritis CVA High cholesterol Otosclerosis Asthma Depression Hypertension Seasonal Allergi Birth disorder Diabetes Hyperthyroidism Seizure disorder Bleeding disorder Emphysema Hypothyroidism Sleep disorder Cancer GERD Intestinal disorder Stomach ulcer Chronic infection ENT Syndromes Irregular heart rate Tinnitus Congestive heart failure Grave's disease Kidney disorder Vertigo Complications related to mesthesia Patient's Past Surgical History: Please list any surgeries you have had and the approximate date.	Cobacco Use: Current	Former Never	Alcohol Use: No	Yes Former
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Patient's Past Surgical History: Please list any surgeries you have had and the approximate date.	Congestive heart failure	Grave's disease	Kidney disorder	Vertigo
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Surgery Appx. Da	Patient's Past Surgical		geries you have had and the	
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