Name:_____ Date of Birth: __/____/____

Past Surgical History

Name of Surgery	Year	Surgeon	Hospital

Past Medical History

Health Problems:		

Family History:

Family member	Health problems
Father	
Mother	
Siblings	

Have you EVER smoked cigarettes/cigars? YES or NO

If YES: How many packs per day did/do you smoke on average for your lifetime? _____

How many years TOTAL have/did you smoke? _____

Did you QUIT smoking? YES or NO

If YES: When? _____

How many doses of antibiotics have you taken for respiratory problems in the last year? _____

How many doses of steroids have you taken for any reason in the last year? _____

Patient Name:_____ Date of Birth:_____

Medication List

Please include over the counter medications and supplements

_____ check here if NO medications

Drug Name	Dosage Strength (mg/mcg)	How many times a day?

Preferred Pharmacy:_____

Address:_____

Phone:_____

Allergies to Medication: _____