DOB: _____ Name: _____ Date: _____

Patient Medical Information

Are you currently taking any daily or prescription medications? Yes No

If yes, please list below - the name, dosage, and prescribing physician for each medication.

_____

_____

_____

_____

Are you currently being treated for PAIN MANAGEMENT? Yes No

If yes, by who? _____

Who is your Primary Care Physician (PCP)? _____

Do you have any drug allergies? Yes No

If yes, please list below:

_____

_____

_____

Have you recently experienced any of the following? If yes, please circle:

Chest Pains	Nausea	Vomiting	Unexplained Weight Loss / Gain
Abnormal Heartbeat	Fever	Blood in Stool	Changes in Bowel Movements
Shortness of Breath	Cough	Skin Complaints	Genital / Urinary Complaints

When was your last menstrual cycle? _____

What is your current form of birth control? _____

When was your last Pap-Smear? _____

When was your last Mammogram? _____

When was your last Bone-Density/DEXA scan? _____

What is your hospital of choice? _____

What pharmacy do you use? Name:_____ Location: _____

Have you had any surgeries? Yes No

If yes, please list type and date of surgery below:

_____

_____

How many pregnancies have you had? _____ Living Children _____ Miscarriages/Abortions_____

Do you currently smoke or use tobacco? Yes No How much per day? _____

Do you drink alcohol? Yes No How much per week? _____

Do you use street drugs? Yes No

DOB: _____ Name: _____ Date: _____