Do you currently use tobacco products _____Yes _____No If yes, what type of tobacco? ________________________

Drug Allergies: ____

Medications: ____

Patient Past Medical History	YES	NO
Hayfever, Asthma, Sinus		
Cancer		
Diabetes		
Heart Disease, Lung Disease		
Hepatitis		
High Blood Pressure		
Kidney Disease		
Skin Cancer		
Skin Disorders		
Thyroid Disease		
Tuberculosis		
Stomach Ulcers		
Are you pregnant?		
Anemia		
Chemotherapy		
HIV		
Anesthesia Allergies		

Past Surgeries/Hospitalizations (Within Past 5 Years)

Date and Type of Surgery	Anesthesia Complications Y/N	Details

FAMILY HISTORY	YES	AFFECTED FAMILY MEMBER
Anesthesia Problems		
Autoimmune Problems		
Cancer		
Diabetes		
Drug Allergies		
Endocrine Disease		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Liver Disease		
Skin Cancer		
Skin Disease		

E-Mail Address: ____

Pharmacy of Choice: ____