MAJOR ILLNESSES, HOSPITALIZATIONS & SURGERIES

List any of these that you had in the past.

Identify these and their associated date(s)

MEDICATIONS

Please list prescriptions and non-prescription medicines, vitamins, herbs, etc. that you take, as well as the dose taken and how many times taken per day.

Identify all Prescription Medications you take, dosage and how often (frequency)

Identify all Over-the-Counter Medications you take, dosage and how often (frequency). Be sure to include all vitamins

ALLERGIES

Do you have any allergies or known reactions to foods, latex and medications?

List all allergies and reactions

VACCINATIONS

Have you had the following vaccinations?

TETANUS ☐ Yes ☐ No
If yes, estimated date: _____

HEP A ☐ Yes ☐ No
If yes, estimated date: _____

HEP B ☐ Yes ☐ No
If yes, estimated date: _____

FAMILY HISTORY

Please indicate family members with any of the following conditions:

Alcoholism _____

Cancer, specify type _____

Heart disease _____

Anxiety/depression/suicide _____

Blood disorders _____

Genetic disorders _____

Diabetes _____

Kidney disease _____

Anesthesia complications _____

High cholesterol _____

High blood pressure _____

Stroke _____

Lung problems _____

Asthma _____

Alzheimer's disease _____

Other _____