

Past surgeries (include year):

Has a family member had a problem with:

1. His/her heart or blood vessels? No Yes Details: _____
2. His/her lungs? No Yes Details: _____
3. His/her stomach or other gastrointestinal organs? No Yes Details: _____
4. His/her joints, muscles or bones? No Yes Details: _____
5. His/her hormones or glands? No Yes Details: _____
6. His/her nerves? No Yes Details: _____
7. His/her liver or blood? No Yes Details: _____
8. His/her skin or immune system? No Yes Details: _____
9. Any cancers? No Yes Details: _____
10. Other? _____

Current Medications:

Rx Name	Strength (mg)	Directions (times per day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies:

For Office Use Only

Reviewed with patient/family: _____

Initial & Date