Patient Name: ______________________________ DOB:___/___/_____

Pharmacy: _____________________________ Phone:_______________

Address: ____

Medication(s)	Strength	Dosage	Frequency
Example: Cipro	250 mg	1 tablet	2 x a day

Name:_____ DOB:_____ Date:_____

DRUG ALLERGIES:

_____
_____
_____

HOSPITALIZATIONS:

Date: Reason:

_____
_____
_____
_____

SURGERIES:

Date: Reason:

_____
_____
_____
_____

CURRENT MEDICATIONS & STRENGTHS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Pharmacy Name,Location,Ph#_____

Primary Care Physician:_____

Family History: **Any Diseases that run in the family?**

Father _____
Mother _____
Spouse _____
Son (s) _____
Daughter (s) _____
Siblings _____
Pets _____

SOCIAL INFORMATION:

Alcohol Use:_____
Type of Alcohol:_____
How Much Daily?_____
How Many Years?_____
Tobacco Use: Yes_____ No _____
How Much Daily?_____
How Many Years?_____
When Did You Stop?_____
EXPOSURES: (Have to been exposed to any of the following?)
Asbestos? Yes_____ NO_____
Sandblasting? Yes _____ NO_____
Toxic Fumes? Yes_____ NO_____
Explain:_____

PAST MEDICAL HISTORY

[ ] Rheumatic Fever
[ ] Headaches
[ ] Congestive Heart Failure
[ ] Heart Palpitations
[ ] Irregular Heart Rate
[ ] Diabetes
[ ] Heart Murmur
[ ] Allergies / Hay Fever
[ ] Arthritis
[ ] Ulcer
[ ] High Cholesterol
[ ] Dizziness / Fainting
[ ] Stroke
[ ] TIA
[ ] Anemia
[ ] Chest Pain
[ ] Angina
[ ] Blood Clot In Legs
[ ] Nervous Breakdown
[ ] High Blood Pressure
[ ] Bronchitis
[ ] Valley Fever
[ ] COPD
[ ] Emphysema
[ ] Pneumonia
[ ] Hemoptysis
[ ] T.B. Skin Test
[ ] Tuberculosis
[ ] Lung Cancer
[ ] Fluid In Lungs
[ ] Shortness of Breath

PERMISSION FORM TO RELEASE MEDICAL INFORMATION

I _____, DOB: _____ hereby grant
(Patient Printed Name)
permission to:

_____
(Name of friend, relative, spouse, attorney, etc. granting to release medical information to)

To receive (mark YES or NO on the items you are granting permission to be released)

_____ Medical information on my behalf.

_____ Pick up prescriptions on my behalf.

_____ Verify appointments on my behalf.

_____ Receive copies of medical records on my behalf.

_____ I authorize permission to leave messages on my voicemail.

_____ I authorize permission to fax my medical information to my home.

I am providing my physician a copy of the following documentation to keep in my medical file, (mark YES or NO if you have the following documentation)

ADVANCED DIRECTIVES: _____
HEALTH POWER OF ATTORNEY: _____
LIVING WILL: _____

This form will remain in effect until I revoke permission with a written notification.

Signature of Patient: _____ Effective Date: _____

Printed Name of Patient: _____