NAME_____ EMR#_____(Office will fill in)

1. Please list any medical conditions or problems you have (like high blood pressure, diabetes, cholesterol, arthritis, heart or lung problems, etc.).

2. Please list the names and doses of the medicines you take regularly (including birth control and over-the counter).

3. Are you allergic to any medicines or to Latex?

4. Have you ever had an operation (like appendix or tonsils) or other procedure (like colonoscopy)? What was it? Date?

5. Are there any illnesses that run in your family (like diabetes or cancer for example)?

6. Do you use tobacco?
   ____Currently every day
   ____Currently some days
   ____Formerly
   ____Never Did

7. Do you drink alcohol?
   ____Never
   ____Occasionally/Socially
   ____Weekly
   ____Daily

8. What other doctors do you see for other conditions?

9. Is there anything else you think is important for your doctor to know?

How did you hear about us? Who can we thank for your referral? _____