

PATIENT NAME: _____

REFERRING DOCTOR: _____

DATE: _____

5. **ALLERGIES** - Check all substances you are allergic to:

- Penicillin _____
 - Sulfa _____
 - Other Antibiotics _____
 - Demerol _____
 - Aspirin _____
 - Codeine _____
 - Iodine _____
 - others (Please list) _____
- Morphine _____
 - Local Anesthetic _____
 - Seafood/Shellfish _____
 - Suture Material _____
 - Metals _____
 - Adhesive Tape _____

6. **HABITS**

- How many cups of coffee _____ per day; tea _____ per day; soda _____ per day; milk _____ per day?
- How many cigarettes do you smoke daily? _____
- How much alcohol do you drink per week? _____ Do you drink beer? _____
- Do you currently use recreational drugs? _____

7. **FAMILY HISTORY** - Please list any immediate family members (parents, brothers, sisters or children) that may have/had any of the following:

- Anesthesia Problem _____
- Arthritis _____
- Cancer _____
- Diabetes _____
- Heart Trouble _____
- High Blood Pressure _____
- Stroke _____
- Asthma _____
- Kidney Trouble _____
- Gout _____
- Ulcer _____
- Tuberculosis _____
- Nervous Breakdown _____
- Convulsions _____
- Bleeding Tendency _____
- Other _____

Relationship	If living, age & state of health	If dead, age at death & cause
Father _____		
Mother _____		
Brother _____ Sister _____		
Brother _____ Sister _____		
Brother _____ Sister _____		
Spouse _____		
Son _____ Daughter _____		
Son _____ Daughter _____		
Son _____ Daughter _____		

I have reviewed and concur _____ Date _____
PHYSICIAN and/or NURSE