Current Medications: Check here_____ if you take no medications.

_____ _____ _____

_____ _____ _____

Allergies to Medications: Please list any medications to which you are allergic: NONE

_____ _____ _____

_____ _____ _____

Which pharmacy do you use? _____ City_____

Social History:

Occupation: _____

PRIMARY DOCTOR:

_____

Smoking History: Please check one of the following:

- ☐ Never smoked
- ☐ Current every day smoker
- ☐ Current occasional smoker
- ☐ Former smoker

Alcohol history: Please check one of the following:

- ☐ None
- ☐ Less than one drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Female Patients:

Are you pregnant? Yes No Due date: _____

Are you breast-feeding Yes No

Signature: _____ **Date:**_____