NAME: ______________________________ AGE:_______ DATE OF BIRTH: ____/____/_______
OCCUPATION:______________________________ PERSON WHO REFERRED YOU: _______________
TODAY'S DATE:____________________ ____

PERSONAL HISTORY:

Do you drink alcohol? **YES** **NO** How much alcohol do you drink on the average? _____ per day_______ per week
Are you on a special diet? **YES** / **NO** What diet?______________________________
Have you recently gained or lost weight? Gained:___________ Lost:_______________ Neither:___________

Advance Directive: **YES** / **NO** Flu Shot: **YES** / **NO** if **yes** when:__________________________
Pneumonia vaccine: **YES** / **NO** if **yes** when :______________________________________
Covid Vaccine **YES** / **NO** if yes provide dates**:** ____

ALLERGIES:

List any medication allergies and reactions:

____

____

MEDICATIONS:

List all medications currently taking:

NAME:	STRENGTH:	HOW OFTEN:

SURGERIES/OPERATIONS:

Have you had any of the following operations?

	NO	YES	DATE	TYPE OF SURGERY
Appendix				
Colon				
Gallbladder				
Hernia (rupture)				
Hemorrhoids				
Kidney				
Prostate				
Small Intestine				
Stomach				
Thyroid				
Tonsils				
Other surgery				
Other hospitalizations				