



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	_____	_____	_____	_____