

List medications you are currently taking, along with dosage and frequency?

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List allergies and/or type of adverse reaction to medication?

\_\_\_\_\_

List previous surgeries and dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had anesthesia? no yes

Describe any problems with local anesthesia: \_\_\_\_\_

Describe any problems with general anesthesia: \_\_\_\_\_

Has anyone in your family ever had a high fever or other problems with anesthesia? no yes

**REVIEW OF PAST, FAMILY AND/OR SOCIAL HISTORY (PFSH)**

Are you  right-handed or  left handed?

Work in the home  Employed  Student  Retired

Occupation \_\_\_\_\_

Do you live?  Alone  With spouse/partner  With family/children  With friend

Exercise?  Daily  Weekly  Monthly  Rarely  Never

What type of exercise? \_\_\_\_\_

Is your weight stable?  Yes  No \_\_\_\_\_ pound  gain or  loss over past 12 months.

History of substance abuse  No  Yes What? \_\_\_\_\_

Do you smoke currently?  No  Yes \_\_\_\_ packs per day for \_\_\_\_ years

Quit smoking?  This year  >1 year  >5 years  >10 years

Previously smoked \_\_\_\_ packs per day for \_\_\_\_ years

Please list **any** information concerning your past, family and/or social history that would affect your symptoms/chief complaint, your treatment(s) to date or beginning at this time and/or any social factors affecting your medical care.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient signature \_\_\_\_\_

Date \_\_\_\_\_

ROS or PFSH Updates: