Medical Information

Patient Name: ___________________________________ **DOB:** ____________________ **Height & Weight:** ___________________

Preferred Pharmacy: ____

Please list ALL Medications you are taking. Include prescription and over the counter:

IF YOU HAVE UPDATED YOUR MEDICATIONS IN BSW MYCHART, YOU DO NOT HAVE TO LIST THEM AGAIN

Medication: ____ Dosage: ________________________

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Medication: ____ Dosage: ________________________

Medication: ____ Dosage: ________________________

Medication: ____ Dosage: ________________________

Medication: ____ Dosage: ________________________

Medication: ____ Dosage: ________________________

Medication: ____ Dosage: ________________________

Medication: ____ Dosage: ________________________

Medication: ____ Dosage: ________________________

Please list all medication allergies: ____

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Please list all surgeries: ____

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Have you ever been diagnosed with any of the following medication conditions? Please circle all that apply:

Anesthetic Complications

Arthritis	DVT	Hyperthyroidism
Cancer	Fractures	Hypothyroidism
Carpal Tunnel Syndrome	Gout	Lung Disease
Chest Pain	Heart Disease	Osteoporosis
Clotting Disorder	Hyperlipidemia	Rheumatoid Arthritis
Diabetes Mellitus	Hypertension	Symptomatic Scoliosis

Daily Consumption of Alcohol: __________________________________ **and Tobacco:** ____________________________________

Signature of Patient/ Parent/ Guardian: ____ **Date:** _________________

Signature of Provider: ____ **Date:** _____________________