

Name \_\_\_\_\_ DOB: \_\_\_\_\_

### MEDICATIONS

List the prescribed and over-the-counter drugs you take.

| Name of Drug | Strength / Dosing Time | Name of Drug | Strength / Dosing Time |
|--------------|------------------------|--------------|------------------------|
| 1. _____     | _____                  | 6. _____     | _____                  |
| 2. _____     | _____                  | 7. _____     | _____                  |
| 3. _____     | _____                  | 8. _____     | _____                  |
| 4. _____     | _____                  | 9. _____     | _____                  |
| 5. _____     | _____                  | 10. _____    | _____                  |

Medication allergies: NKDA  \_\_\_\_\_  
 \_\_\_\_\_

Food allergies: NKFA  Lactose  Soy  Other: \_\_\_\_\_

### SOCIAL HISTORY

Tobacco: No Never  Yes  Quit Past Year  Quit Greater Than a Year Ago

Alcohol: No Never  Yes  Number of Drinks Per Month \_\_\_\_\_

Elicit Drugs: No Never  Yes  Type \_\_\_\_\_ Currently Using Yes  No

### FAMILY HISTORY

Family history of premature cardiovascular disease ("premature is defined as myocardial infarction or sudden death experienced by the father or other male first-degree relative at or before 55 years of age, or experienced by the mother or other female first-degree relative at or before 65 years of age")  Yes  No

Diabetes: Mother  Father  Sibling

Weight Problems: Mother  Father  Sibling

Thyroid Disease: Mother  Father  Sibling

Other List: Mother \_\_\_\_\_ Father \_\_\_\_\_ Sibling \_\_\_\_\_