Current Medication List

Patient Name:_____ Date:_____

Preferred Pharmacy:_____ Address:_____ Phone:_____

1. _____Dosage:_____ Frequency:_____
2. _____Dosage:_____ Frequency:_____
3. _____Dosage:_____ Frequency:_____
4. _____Dosage:_____ Frequency:_____
5. _____Dosage:_____ Frequency:_____
6. _____Dosage:_____ Frequency:_____
7. _____Dosage:_____ Frequency:_____
8. _____Dosage:_____ Frequency:_____
9. _____Dosage:_____ Frequency:_____
10. _____Dosage:_____ Frequency:_____

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

By signing below I give permission, without limitation or exclusion, to Dr. Conrad J. Tirre And his office staff to view my external prescription history for purposes of my care and treatment. I understand that my medication history from multiple other medical providers, insurance companies, and pharmacy benefit managers is available and viewable, and that granting this permission will allow my providers to better coordinate my care and to maximize the effectiveness and safety of my treatment plan and visit. I certify that I read and understand the scope of my consent and that I authorize access.

Signature of Patient or Representative:

_____

( ) Self ( ) Parent ( ) Legal Guardian ( ) Representative/Health Care POA

Medical and Health History Form

Patient Name:_____ Age:_____ Birthdate:_____

Please answer <u>all questions</u> as accurately as possible. If you do not understand the question, please ask for assistance.

Reason for today's visit: _____ Primary care doctor: _____

Do you smoke nicotine? *Yes No* Amount per day_____How soon upon waking _____

Are you ready to quit? *Yes No* Do you drink alcohol? *Yes No* Do you use Marijuana? *Yes No*

Height _____Weight_____ Have you had a flu shot? *Yes No* When? _____

Do you have an Advanced Directive? *Yes No* Do you have a Latex Allergy? *Yes No*

<u>Drug Allergies</u>:_____

List previous surgeries (Cosmetic and medical) and dates:

_____

<u>Family History:</u>

Have any **<u>immediate family member(s)</u>** ever had the following: (**please circle F-father; M-mother; S-sister; B-brother**)

□Breast Cancer F M S B	□ Melanoma F M S B	Father: Alive	Deceased
□High Blood Pressure F M S B	□ Heart Disease F M S B	Mother: Alive	Deceased
□Kidney Disease F M S B	□ Depression F M S B	Brother: Alive	Deceased
□Stroke F M S B	□Diabetes F M S B	Sister: Alive	Deceased

<u>Past Medical History:</u>

Have **<u>you</u>** ever had the following:

□Heart Disease	□Arthritis	□Rheumatic Fever	□**NONE**
□Cancer	□Glaucoma	□Asthma	
□Stomach Ulcer	□Kidney Disease	□Thyroid Disease	
□Anemia	□Tuberculosis	□Diabetes	
□AIDS or HIV	□Stroke	□Hepatitis	
□Bleeding Tendency	□Mitral Valve Prolapse	□High Blood Pressure	

□**Other**:_____

<u>Review of Systems:</u>

Do you have or have you had within the past year:

□Weight Change	□Dry Eyes	□Chronic Cough	□**NONE**
□Swollen feet/ankles	□Skin Rash	□Chronic Diarrhea	
□Seizures	□Joint/Muscle Pain	□Swollen Lymph Nodes	
□Chest Pain	□Depression	□Easy Bleeding	
□Jaundice	□Easy Bruising	□Rapid Heartbeat	

<u>Women only:</u>

Date of last mammogram _____ Are you currently breastfeeding? _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. THIS FORM MUST BE COMPLETED BEFORE SEEING THE DOCTOR.

_____ _____

Patient Signature/Guardian Date