**MEDICATION LIST/SOCIAL HISTORY**

131 W. Sunset Rd, Suite 101

San Antonio, TX 78209

Office: 210-255-8447 Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: (210) 255-8446

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL INFORMATION** Height: \_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

Reason for your visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment status: 🞎 Full-time 🞎 Part-time 🞎 Retired 🞎 Homemaker 🞎 Other (specify): \_\_\_\_\_\_

What is your occupation?

Date (Year) of last of the:

Flu shot: \_\_\_\_\_\_\_\_\_\_\_

Pneumonia shot: \_\_\_\_\_\_\_\_\_\_\_\_

Shingles shot: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daily activity level: 🞎 Active 🞎 Moderately active 🞎 Sedentary

Do you have an advance directive? 🞎 No 🞎 Yes

If yes, who is your surrogate decision maker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever or do you currently:

🞎Smoke Frequency: How long?

🞎Use alcohol Frequency: How long?

🞎Use drugs Frequency: How long?

**ALLERGIES**

Do you have any allergies to include medications, food, iodine, shellfish? Please list what type of reaction you had. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**MEDICATIONS**

(Please include over the counter medications and herbal supplements)

|  |  |  |  |
| --- | --- | --- | --- |
| 1. | Medication | Dose & Frequency | Reason |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| 6. |  |  |  |
| 7. |  |  |  |
| 8. |  |  |  |
| 9. |  |  |  |
| 10. |  |  |  |

Please continue on the back side if more room is needed.

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_