Patient Questionnaire Page 2

PRESENT MEDICATIONS (Include birth control pills and over the counter medications, example: Supplements)

MEDICATION	DOSE	HOW OFTEN

DRUGS YOU ARE ALLERGIC TO:

MEDICATION	REACTION (WHAT HAPPENED WHEN TAKEN)

OPERATIONS YOU HAVE HAD:

OPERATION	SURGEON	YEAR

HABITS	YES	NO	
Do you or did you ever smoke cigarettes?			How many packs per day?
Do you drink alcohol?			How many drinks per day?
Do you or did you ever use street drugs?			What drugs?
Do you regularly drink coffee?			How many cups per day?
During the past month, have you often been bothered by feeling down, depressed, or hopeless?			
During the past month, have you often been bothered by little interest or pleasure in doing things?			

FAMILY HISTORY (List known conditions and diseases of any blood relative in your immediate family. Also include intellectual disability and birth defects.)

CONDITION	RELATIONSHIP

Preferred Pharmacy: _____ City: _____