Patient Health History

Are you taking any current medications, if yes please list below:

Any known allergies to medications, if yes please list below:

Pharmacy:

Smoking Status: Current ____ Former ____ Never___

Vape____ Cigarettes ____ Chew/Snuff_____ Cigar_____

For provider use :

Vitals :

BP _______________ Weight _______________

Pulse _______________ Height _______________

Temp _______________ Pulse Ox _______________

Resp _______________ Pain ___/10 Location _______________