

Cardio Vascular Surgeons of North Texas

Name: _____ D.O.B _____ Date: _____

ALLERGIES: Please list any drug or substance to which you are allergic and the type of reaction you had.

DRUG OR SUBSTANCE	TYPE OF REACTION

Medication that you are currently taking:

NAME OF MEDICATION	QTY TAKEN PER DAY	NAME OF MEDICATION	QTY TAKEN PER DAY

Do you now or have you ever used any of the following:

	YES	NO	AMOUNT PER DAY
ALCOHOL.....	_____	_____	_____
CIGARETTES/CIGARS/PIPES.....	_____	_____	_____
SNUFF.....	_____	_____	_____
ILLEGAL DRUGS.....	_____	_____	_____

PATIENT SIGNATURE
DATE

RELATIONSHIP (If not signed by patient) _____