Medical Conditions/Surgical History & Medications - Past/Current

Date: _____

Patient Name: _____

CURRENT or PAST CONDITIONS: (Please list any current or past diagnoses)

1._____

2._____

3._____

SURGICAL HISTORY: (Please list any past surgeries you have had)

1._____

2._____

3._____

MEDICATION HISTORY

**** ATTN NEW PATIENTS: Dr. Lakin does not prescribe or manage chronic/long term pain medications. This practice refers to the recommended Pain Clinics on our website for prescribing and management.**

DRUG ALLERGIES

1._____ 2. _____

PRESCRIPTION MEDICATIONS: Please list all medicines or drugs being taken **NOW** that were **PRESCRIBED BY A DOCTOR** (include what you take for chronic conditions, birth control, etc., AND any OTC medication such as aspirin, antacids, sleep medicine, allergy, cold medicine, vitamins).

*****CONTINUE MED'S ON REVERSE SIDE IF NECESSARY OR IF YOU DO NOT HAVE A LIST WITH YOU*****

MEDICINE NAME	DOSAGE	HOW OFTEN TAKEN
1.		
2.		
3.		
4.		
5.		

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