NAME:_____ DATE OF BIRTH:_____

REASON FOR CONSULTATION:_____

_____

_____

ALLERGIES: (please list reaction to each medication)

_____

_____

_____

_____

_____

MEDICATIONS: list all vitamins, supplements and over the counter medications

_____

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_____

Will you allow Texas Breast Specialists to obtain your medication history electronically from your pharmacy?

YES NO

PHARMACY:

NAME:_____

PHONE NUMBER:_____

CROSS STREETS:_____

_____

IS THERE ANY OTHER INFORMATION YOU WISH US TO KNOW?

_____

_____

_____

_____

_____

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_____

I certify that the information I have provided is correct. I will not hold my doctor or members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature:_____Todays date_____