Zbigniew Moszczynski, M.D., F.A.C.S.

Confidential

Patient Name _____Today's Date _____Date of Birth _____

Pharmacy Name _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

Allergens

Shellfish	▢ No ▢ Yes	Iodine	▢ No ▢ Yes	Latex	▢ No ▢ Yes
Penicillin or other antibiotics	▢ No ▢ Yes	Morphine, demerol, or other narcotics	▢ No ▢ Yes	Novocaine or other anesthetics	▢ No ▢ Yes
Other drugs or medications	▢ No ▢ Yes	Aspirin or other pain remedies	▢ No ▢ Yes	Tetanus antitoxin or other serums	▢ No ▢ Yes

Other allergies:_____

Current Medications

Medication	Dosage (mg)	Times daily	Medication	Dosage (mg)	Times Daily

Are you currently taking aspirin? ▢ No ▢ Yes

Hospitalizations and Surgeries

Year	Reason	Year	Reason

Have you ever had a blood transfusion? ▢ No ▢ Yes If Yes, When? _____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor;s office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____

Signature of Patient (or parent/guardian if minor) Date