ROBERT FELD, M.D.,F.A.C.S., LLC

MEDICATION, ALLERGY, HOSPITALIZATION & SURGERY QUESTIONNAIRE

Date ____ Chief Complaint _________________________________

Name ____ Duration _______________________________________

Date of Birth ___________________________________ Regular Doctor __________________________________

Referring Doctor _________________________________

Medications and Supplements, Please List All:

Medication or Supplement Name	Dosage (Amount)	How Often Taken

Name of your Pharmacy: ___________________________________

Telephone Number of your Pharmacy: ___________________________________

Address of your pharmacy: ____

Medications your are allergic to	Reaction

Do you have any other allergies (examples: hay fever, food)

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Reasons for hospitalizations in the past two years, not including surgeries.

List Surgeries