Stuart R. Winthrop, M.D.

Patient Name: ________________________________ **Date of Birth:** _______________ **Date:** ___________

SOCIAL HISTORY:

Student Homemaker Employed Retired Single Married Separated Divorced Widowed

Do you use Tobacco? Yes No; if yes:
Cigarettes Smokeless _______ # Packs/Times Day _________ # of Years

Do you use Alcohol? Yes No; if yes:
Rarely Daily Weekly; 1-2 drinks 2-4 drinks Other___________________________________

Substance Abuse? Yes No; if yes:
Rarely Daily Weekly Other____

LIST ANY DRUG ALLERGIES: ____

List all Prescriptions and Over the Counter medications you are taking: (Including Eye Drops)
If you have a list, please give to receptionist to copy in lieu of filling out form:

Medication Name	Dosage	Taken how often? PRN= when needed	Route	Reason for taking	Currently Taking Yes	No
		___ Times a day ____ or PRN	Oral Topical Injection			
		___ Times a day ____ or PRN	Oral Topical Injection			
		___ Times a day ____ or PRN	Oral Topical Injection			
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		___ Times a day ____ or PRN	Oral Topical Injection			
		___ Times a day ____ or PRN	Oral Topical Injection			
		___ Times a day ____ or PRN	Oral Topical Injection			

REVIEWED:

Staff	*Date*

☐ Patient refused to fill out form

Physician Signature: ____ Date: __________________

Use back of sheet if needed>>>

All information you provide is confidential and will not be released to anyone without your consent
Use back of form for any additional information that you need to add.

08/2017

Stuart R. Winthrop, M.D.

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Staff	*Date*

Physician Signature: ______________________________ Date**:** ______________________

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