PATIENT HISTORY

Fill in the WHITE SPACES completely. Use the back of this page if more space is needed Do not fill in grayed out sections - these should be completed by the office staff.

MEDICAL HISTORY List any current or past medical conditions MEDICATION LIST List any past surgeries / procedures MEDICATION LIST List all medications you are currently taking with the dose and instructions(ex: twice a day) include OTC med. witamins, and supplements. ALLERGIES List any medication allergies and reactions SOCIAL HISTORY Marital Status Occupation How often do you wear a seatbelt while in the car? (always/sometimes/never) What kind of regular exercise do you do? How often do you exercise? Do you currently use drugs? How much? (ex: daily, monthly, yearly) Do you currently dink alcohol? How much? (ex: daily, monthly, yearly) Do you currently use tobacco? (cigarettes, cigare, e-cigarettes, vapes, chewing tobacco, etc.) Do you currently consume caffeine? (tea, coffee, soda, etc.) FAMILY HISTORY FAMILY MEMBER AGE (current/at death) MEDICAL PROBLEMS MOther Father IMMUNIZATION & SCREENING HISTORY List the most recent date for each below (if applicable) Immunizations Tetanus Fiu Preumonia Shingles HPV Hep A Hep B Colonoscopy Test for Blood in Stool MEN ONLY PSA (blood test) Mennoss/Period Pap Mammogram Mennoss/Period Pap Menmogram Mennonics				••••	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 1		
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