PATIENT MEDICAL INFORMATION

Today's Date: _____ **Patient Nickname:_____**

Patient Name: Prefix _____ Last _____ First _____ MI ____

Date of Birth: _____ **Marital Status:** Married Single Partnered Separated Divorced Widowed

If Patient is a child, list parents' names: 1. _____ 2._____

Height:_____ Weight: _____ Primary Physician: _____

E-mail: _____ Spouse's Name: _____

Preferred Pharmacy: _____ Phone: (_____) _____

Street (or cross-streets)_____ City: _____

REASON FOR TODAY'S VISIT: _____

Brief History of the problem: (When did it begin? What are the symptoms? Does anything make it better or worse? Have any medications been tried, etc.?)

_____

_____

_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dose	Name of Medication	Dose
Check if none ☐			

Do you take aspirin daily? Yes ____ No ____

Chemotherapy in past? If yes, please list medication(s): _____

ARE YOU ALLERGIC TO ANY MEDICATION? Yes ____ No ____ If yes, please list below:

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS:

List Surgeries: Check if none ☐ _____

_____

_____

List Hospitalizations (for non-surgical reasons): Check if none ☐ _____

_____