

Patient Name: _____ Birth date: _____

Chief Complaint: _____

Medications: List medications you are currently taking.

Name	Strength	Directions	Medication Allergies
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical History

Surgical History

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Health Habits: Check (✓) which you use and how much you use

- Caffeine _____ Tobacco _____
 Street Drugs _____ Alcohol _____

Pharmacy Information

Name: _____

Phone: _____

Address: _____

Family History

Relation	Age	Health Status	Medical Conditions/Problems
Father			
Mother			
Siblings			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Sons			
Daughters			
Paternal Uncles			
Paternal Aunts			
Maternal Uncles			
Maternal Aunts			