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Patient Name: _____ *DOB:* _____ *Date:* _____

Family History

Y	*N*	***Description***	*Y*	*N*	***Description***
❑	❑	*Diabetes* _____	❑	❑	*Heart Trouble* _____
❑	❑	*Cancer*_____	❑	❑	*Congenital Problems* _____
❑	❑	*High Blood Pressure* _____	❑	❑	*Other* _____

Past Patient History

Y	*N*	
❑	❑	*Drug Allergies (Name of medicine and reaction:*_____
❑	❑	*Have you been diagnosed with a serious medical illness?:*_____
❑	❑	*Have you had any operations/hospitalizations/injuries?:* _____

Today's Visit

Y	*N*	
❑	❑	*Are you currently taking any medications?:* _____
❑	❑	*What problems/concerns would you like to discuss with the physician?:*_____