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Patient Name: _____ DOB: _____ Date: _____

Family History

Y	N	Description	Y	N	Description
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble _____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Problems _____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	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?: _____

