

Initial History

Patient Name: _____ Date of Birth _____

Address: _____ Town: _____ State _____ Zip _____

Phone: () _____

Residence: _____ Live alone _____ Live with others

Relative/ Friend Contact: _____ Relationship: _____

Address: _____ Town: _____ State: _____ Zip: _____

Phone: () _____

Pharmacy: _____ Town: _____ Phone: () _____

Current and Past Medical History

What are your current medical concerns? _____

How is this problem affecting your daily life? _____

Do you presently have any other medical problems? _____

List any Surgical Procedures you have had

Procedure

Date

a) _____

b) _____

c) _____

d) _____

List all the medications you are presently taking; both those you take daily and those you just take once in a while. Please include Vitamins, mineral supplements, laxatives, stool softeners, and prescription skin preparations. If you cannot remember the names write a “?” and bring the medicines with you to your next visit.

Medicine name

Strength

How Often

Reason
