Name _____

DOB _____

Primary Doctor _____

Reason for visit _____

Height: _____ Weight: _____

Problems: Asthma Diabetes High blood pressure GERD Thyroid Arthritis

_____ _____ _____ _____

Surgeries:

_____ _____ _____ _____

Mother Alive Y/N Diabetes High blood pressure Cancer
Father Alive Y/N Diabetes High blood pressure Cancer

Smoking: Y/N/Quit
Alcohol: Y/N/Quit
Drug use: Y/N/Quit
Occupation: _____

How many pregnancies? _____
Miscarriage? _____
Living children: _____

Medications (with dose please)

_____ _____ _____ _____

_____ _____ _____ _____

Medication Allergies

_____ _____ _____ _____