PATIENT MEDICAL INFORMATION
(Please Print)

Date ______________ Birthdate ______________ Age ______

Patient Name ______________________________ M / F (circle one)

Pharmacy Name ______________________ Phone # ______________

Medication Allergies (List drug name and reaction)

1) ______________ 2) ______________

3) ______________ 4) ______________

Past Surgical History (Includes biopsies, D&C's, tonsillectomy, etc.)

1) ______________ 2) ______________

3) ______________ 4) ______________

Medical Problems (Past and Present: include serious injuries and any fractures)

1) ______________ 2) ______________

3) ______________ 4) ______________

5) ______________ 6) ______________

Current Medication with Dosage (Including Non-Prescription drugs)

1) ______________ 2) ______________

3) ______________ 4) ______________

5) ______________ 6) ______________

OB-GYN History

# of Pregnancies _____ # Live Births _____ # of Stillborn/Miscarriages _____ Last GYN Exam ______________

Name of your gynecologist: ______________________________

Have you gone through menopause? Yes _______ No _______

If so, what age? _______

When was your last mammogram? ______________________

Other

When was your Chest X-ray? ______________________

Date of most recent immunizations: tetanus ___________ flu ___________ pneumonia ___________

Have you had a DEXA scan? Yes _______ No _______

If so, when was your last scan? ______________________

When was your last PPD (TB skin test)? ______________________

Positive _______ Negative _______