Today's Date: _____

PATIENT NAME _____(nickname)_____

DOB:_____M/F

ALLERGIES/REACTIONS:_____

ILLNESSES:_____

Circle if you are being treated for Diabetes, High Blood Pressure, or Hypertension.

SURGERIES_____

HOSPITALIZATIONS_____

CURRENT MEDICATIONS/DOSAGE(include over the counter products/vitamins) Circle if NONE.

_____

_____

Social History: S/M/D/W (spouse's name if applicable)_____

EMPLOYER:_____

Alcohol use: Y/N Tobacco use: Non / Current / Former

Family Health History of Illness/Cause of Death:

Alive/Deceased Mother_____

Alive/Deceased Father_____

Race:_____(Caucasian, Hispanic, Etc)

Language:_____(English, Spanish, Etc)

Ethnicity:_____(American, Mexican, Etc)