Patient

_____ 8/29/202
Full Name Date

Reason for your visit today, including duration of symptoms:
Reason for visit and symptoms . . .

Have you had adverse reactions to any prescription medication?

☐ Yes

☐ No

If so, what medications? Medications with adverse reactions . . .

Current medications you are taking prescribed by any doctor:
Current prescriptions . . .

Current over-the-counter preparations / medications you use:
Current over-the-counter medication . . .

Questions you would like to ask during today's visit?

1. Question
2. Question
3. Question
4. Question
5. Question

OFFICE USE ONLY

Verified with patient_____ Updated computer_____