MEDICAL HISTORY

Name: _____ Date: _____

List Allergies that you have: _____ None: ____

Primary Care Physician: _____

Physician Phone: (___) _____

Physician Address: Street _____City _____ State___ Zip_____

Date of your most recent physical examination: _____

List all current medication(s) and dosages:

Medication	*Dosage*	*Prescribing Doctor*	*When did you start taking*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all current and past health problems and major surgeries/procedures:

Current	*Past*
_____	_____
_____	_____
_____	_____
_____	_____

List all therapists you have seen and dates that saw them:

_____	_____
_____	_____
_____	_____
_____	_____

List any substance abuse treatment or inpatient psychiatric treatment you have had and the dates:

_____

_____

_____

_____