

ALLIANCE MEDICAL CENTER, P.C.

NAME: _____ DATE: _____

What is your current complaint?

What have you tried as treatment, including over the counter and physicians medicines?

What other medical problems would you like to discuss?

Please list ALL previous hospitalizations or surgeries.

Please list *all* medications you are taking, including over the counter and natural products.

Please list blood relatives (especially parents and siblings) that have had:

Heart disease _____

Diabetes _____

Cancer (especially Prostate, Colon, Lung & Breast/Ovary) _____

High Blood Pressure _____

Mental Illness _____

Do you smoke? _____ If yes, packs per day _____ Number of years _____

Do you drink alcohol? _____ Illicit Drug Use? _____

Do you exercise? _____ Last Tetanus Shot? _____

Do have a Living Will? _____ If a child, are immunizations current? _____

Have you ever had a Melanoma ? _____

Please list any allergies to medications you may have _____

Who referred you to Alliance Medical Center, PC? _____