PATIENT NAME:________________________________ **DATE OF BIRTH:**______________

SELF PAY: Y or N ***CareFirst HMO or United Healthcare***

REASON FOR TODAY'S VISIT:

____

____

Primary Care Provider: ________________________ **Pharmacy:**_________________________

Past/Current Medical History:

- ☐ **Allergies (medications/food):**
  ____
  ____
  ____
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer: ___________________________
- ☐ COPD
- ☐ Depression/Anxiety/ Bipolar
- ☐ Diabetes: Insulin Dep or Non-Insulin Dep
- ☐ Heart Problems: _____________________
- ☐ Gallstones
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Stones
- ☐ Migraines
- ☐ Seizures
- ☐ Thyroid Disease: ____________________
- ☐ Tuberculosis: ______________________
- ☐ Other: ____________________________
  ____

Surgical History:

____

____

____

____

Date of Last Menstrual Cycle: ________________

Pregnant? YES or NO How many weeks? ______

Do you drink or smoke? _____________________

Daily Medications:

Medication Name	Strength/Dose

Patient/ Guarantor Signature: ___________________________________ **Date:**____________

OFFICE USE ONLY Room: _________

Height: ____________ Weight: __________

Temperature	Pulse	Blood Pressure	Respiration Rate	O2 Sat	Pain