Please list medicines you+A1:G37 are taking. Include all prescriptions, non-prescription, and over-the-counter (OTC) medicines- including inhalers, vitamins, herbs, and supplements.			
Medicine Name	Strength	Dose	Who ordered this medicine?

Please list any allergies:

Medical/Family History: Please check the appropriate boxes

Disease	Self	Father	Mother	Brother/Sister	Children	Grandparents
Cancer	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐
Asthma/COPD	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Alzheimer's Dementia	☐	☐	☐	☐	☐	☐
Parkinson's	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

Please specify:

Please list any surgeries or procedures, along with date

Preventative Health

Preventative Service	Date last received
Mammogram	
Pap test +/- HPV test	
Bone density scan	
Colonoscopy	
Prostate Cancer Screening	
Immunizations	
Flu	
Pneumococcal	