

FALLS MEDICAL SPECIALISTS, LLC

NAME: _____ DATE: _____

WHY ARE YOU HERE TODAY? _____

ALLERGIES: Are you allergic to foods, drugs, or environmental substances? Please list:

_____ reaction _____

_____ reaction _____

_____ reaction _____

_____ reaction _____

HOSPITALIZATIONS, SURGERIES, SPECIAL TESTING:

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

Mammogram:

Colonoscopy:

Dexa:

Chest X-ray:

IMMUNIZATIONS:

Tetanus Y N Tetanus & Pertussis Y N date given:

Pneumonia: Y N date given: _____

Flu: Y N date given: _____

Hepatitis: Y N date given:

Zostavax (Herpes Zoster): Y N date given:

PRIMARY CARE OR REFERRING PHYSICIAN NAME, LOCATION & PHONE NUMBER:

PHARMACY NAME, LOCATION & PHONE NUMBER: _____

CHRONIC MEDICAL CONDITIONS:

Condition: _____ Specialist: _____

Condition: _____ Specialist: _____

Condition: _____ Specialist: _____

Condition: _____ Specialist: _____

Condition: _____ Specialist: _____

MEDICATIONS (INCLUDING OVER THE COUNTER):

<u>Medication</u>	<u>Dose</u>	<u>How Often Taken</u>	<u>Date started</u>	<u>Prescriber</u>
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THESE QUESTIONS REQUIRED BY U.S. DEPARTMENT OF HEALTH AND HYGIENE

ETHNIC GROUP:

HISPANIC OR LATINO: Y N

LANGUAGE: ENGLISH SPANISH

RACE:

SMOKER: Y N PREVIOUS HISTORY OF SMOKING: Y N DATE STOPPED: