Premier Family Medicine

Patient Profile (all info is about the patient unless otherwise noted)

Patient's Name: _____
Occupation: _____ **Hobbies**: _____
Spouse's Name: _____
Spouses Occupation: _____ **Do you**: **Smoke**____ **How much?** _____
Drink alcohol ____ **How much?** _____

Medical Issues to address at visit

_____
_____
_____
_____
_____
_____
_____

Patient's Allergies

_____
_____
_____
_____

Past Medical Problems

_____
_____
_____

All Current Medical Problems

_____
_____
_____
_____
_____
_____

_____
_____
_____

Surgeries

_____
_____
_____
_____
_____

Current Medications

_____
_____
_____
_____
_____

Women Only

Number of pregnancies _____
Number of children _____
Pregnancy complications

_____
_____

Children:

Name	Date of Birth
_____	_____
_____	_____
_____	_____

Family History

	Living?	Age	Medical Problems
Mother	_____	_____	_____
Father	_____	_____	_____
Brothers	_____	_____	_____
	_____	_____	_____
Sisters	_____	_____	_____
	_____	_____	_____
Others			
_____	_____	_____	_____
_____	_____	_____	_____

Is there anything you would particularly like us to know about you or your family which would help us give you the best treatment possible? _____
_____
_____

Local Pharmacy Info – Name: _____ **Phone:** _____
Address: _____
Mail Order Pharmacy Info – Name: _____ **Phone:** _____
Address: _____