

**Patient**

Full Name \_\_\_\_\_

Date (MM/DD/YY) \_\_\_\_\_

Reason for your visit today, including duration of symptoms:

Have you had adverse reactions to any prescription medication? Yes / No (please circle)  
If so, what medications?

Current medications you are taking prescribed by any doctor:

Current over-the-counter preparations / medications you use:

Questions you would like to ask during today's visit:

- 1.
- 2.
- 3.
- 4.
- 5.

-----OFFICE USE ONLY-----

Verified with patient \_\_\_\_\_ Updated records \_\_\_\_\_