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: ____

OVER

CHRONIC MEDICAL CONDITIONS:

Condition: ____Specialist: ____________________________

Condition: ____Specialist: ____________________________

Condition: ____Specialist: ____________________________

Condition: ____Specialist: ____________________________

Condition: ____Specialist: ____________________________

MEDICATIONS (INCLUDING OVER THE COUNTER):

Medication	Dose	How Often Taken	Date started	Prescriber

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: