Frontier Family Medicine

Board Certified

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Please fill out and help us address your health concerns more efficiently. Thank you!

*If you have been seen here within the previous 3 months and there have been no changes, please check here_____

*If not please list your current medications, including over-the-counter items and supplements. Circle those you need refilled.____

____

____

Pharmacy used: ____

*Have you received any prescriptions from another provider in the past 30 days? YES__ NO__ If so, please explain what the prescription was and what it was treating.

____

____

Personal and Family History:

1. Birth defects/ Hereditary disease
2. Cancer/ Arthritis
3. Blood Problems
4. Diabetes/ Thyroid
5. Eye/ Ear or hearing problems
6. High Blood Pressure
7. Heart attack/ Heart Disease/ Sudden death before age of 55.
8. Rheumatic fever
9. Hay fever/ Allergies
10. Ulcers/ Colitis
11. Asthma/ COPD (emphysema) TB
12. Liver/Gallbladder disease
13. Kidney disease or infection
14. Seizure/ epilepsy/ convulsions
15. Mental condition
16. Skin Problems
17. Alcohol/ drug abuse
18. Tobacco use

Please list the number of the problem, condition, and family member affected:

____

____

____

Please circle one: Married, Single, Divorced, or Widowed. Children_____________ Occupation____________________

Alcohol use: Yes / NO Drug use: Yes / NO Tobacco use (past or current): Yes / NO

List your current and past medical conditions:

____

____

Hospitalizations / surgeries:____

____

Do you have any medication allergies? Please list the medication and the reaction. ______________________________

____

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When was your last: (Female) Mammogram________ PAP________ (Male)________ PSA________

Colonoscopy ________ Tetanus booster ________ (did it contain pertussis? Yes / NO / Donøt know)

Shingles ________ Pneumovax ________ Influenza ________

Reason for todayøs visit ____

____

______________________________ ______________________________ ____________

Patients name | Signature | Date