

OURFAMILYDOCTOR
Dr. Jeffrey B. Taylor
NEW/ESTABLISHED PATIENT HISTORY

Name: _____ DOB: _____ Date: _____

Current Complaints: _____

Medication Allergies: (list or write none)

Alcohol: No/Yes Social Daily **Smoking:** No/Yes Pack per Day: _____ Quit: ___/___/___

Immunization History: (include dates if possible)

Adults: Tetanus: ___/___/___ Pneumonia: ___/___/___ Flu: ___/___/___

Other: _____

Children: (list) _____

Previous Surgeries: {example. Tonsillectomy (date)}

Health Maintenance:

Papsmear ___/___/___ Mammogram ___/___/___ DEXA Bone Scan ___/___/___ Colonoscopy ___/___/___

Medical History: {example. High Blood Pressure}

Family History:

Heart Disease Heart Attack Diabetes Stroke Depression Cancer (list) _____

Medication List:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

DO YOU CONSENT TO TREATMENT ADVISED BY DR. JEFF TAYLOR WHICH MAY INCLUDE INJECTIONS, BLOOD WITHDRAWALS, APPROPRIATE EXAMINATIONS, OR OTHER PROCEDURES AFTER VERBAL EXPLANATION?

YES NO

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT IN ORDER TO PROVIDE TREATMENT?

SIGNATURE _____

DATE _____