FAMILY FIRST HEALTH CENTER PC

333 N MAPLE SUITE 105 SUTHERLAND, NE 69165
familyfirsthealth@gpcom.net
PHONE: 308-386-4799 FAX: 308-386-4343

MEDICAL INFORMATION

Name Today's Date

Date of Birth: Age:

Current Symptoms:

Health Problems and Date of Onset:

Surgeries and Dates:

Hospitalizations and Tests:

Accidents, Injuries, Psychological Trauma, Abuse (with dates):

Significant Dental Work, or Infections or Root Canal (with dates):

Toxic Exposures and Infections (with dates):

Number of Pregnancies: Births: Children:

Occupation

Single ☐ Married ☐ Widowed ☐ Divorced ☐

Do you use and amount/type?

Alcohol Drugs Cigarettes Artificial Sweeteners Soda Pop

What illnesses do your relatives have? Other issues/concerns in your ancestors or family?

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Patient Name: Today's Date:

Medications and dose you are currently taking:

Allergies to Medications:

Pharmacy You Use: _____

(BELOW- FOR OFFICE USE ONLY)

Medications Reviewed and corrected:

Date/initial_____ Date/initial_____ Date/initial_____ Date/initial_____

Date/initial_____ Date/initial_____ Date/initial_____ Date/initial_____

Date/initial_____ Date/initial_____ Date/initial_____ Date/initial_____

Date/initial_____ Date/initial_____ Date/initial_____ Date/initial_____

As needed medications

Pain Plan _____