FAMILY FIRST HEALTH CENTER PC

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

MEDICAL INFORMATION								
Name	Today's Date							
Date of Birth:			Age:					
Current Symptoms:	1110							
Health Problems an	d Date of Onset:							
Surgeries and Dates	y:							
Hospitalizations and	d Tests:							
Accidents, Injuries,	Psychological Tr	auma, Abuse (with da	ates):					
Significant Dental V	Work, or Infection	ns or Root Canal (with	n dates):					
Toxic Exposures an	d Infections (with	ı dates):						
Number of Pregnan	cies:	Births:	Children:					
Occupation								
Single M	Iarried \\	Widowed Divo	orced					
Do you use and amo	ount/type?							
Alcohol	Drugs	Cigarettes	Artificial Sweeteners	Soda Pop				
What illnesses do yo	our relatives have	? Other issues/concer	rns in your ancestors or family?	?				

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Patient Name:			Today's Date:					
Medications and dose you are currently taking:								
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Control of the contro								
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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 medic	cations							
Pain Plan								