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\_\_\_\_\_\_\_\_\_\_\_

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As needed medications 





Pain Plan