WOODS FAMILY MEDICINE

ABBEY L. WOODS, MD

INITIAL VISIT INFORMATION

Patient's Name: ____ Date of Birth: ____________________

ALLERGIES:		
Current Medication Name	Dose	Frequency

Preferred Pharmacy: ____

Medical History	
Born full term? Premature? Any complications with pregnancy or delivery?	

Surgical History	

Social History			
Tobacco Use:	Family member smoke?		
Lives with:			
Siblings?			
Pets?			

Family History	

Previous Physicians (primary care or specialists): Name, Specialty, Phone number, Address	

PLEASE PROVIDE A COPY OF THE MOST RECENT IMMUNIZATION RECORD.

WOODS FAMILY MEDICINE

ABBEY L. WOODS, MD

TODAY'S VISIT INFORMATION:

Patient's Name: ____ Date of Birth: _____________________

Reason for today's visit:____

Any new medications since last visit? NO/ YES (explain) ____

Any new vaccinations since last visit? NO/ YES (explain) ____

Any specialist visit, ER, or hospitalization since last visit: NO/ YES (explain) ______________________________________

Review of Systems:			
Over the last two weeks have you had any of the following: (circle)			
Headache	Blurry or double vision	Nasal discharge/bleeding	Trouble swallowing
Lumps or bumps in neck	Hoarseness	Ear pain	Ringing in ears
Cough	Chest pain	Shortness of breath	Palpitations (heart racing)
Stomach pain	Change in bowel habits	Blood in urine or stool	Numbness or tingling in hands or feet
Fever	Weakness	Dizziness	Leg swelling

Will you need a note for work or school?

NO/ YES ____