Western Washington Medical Group

Whitehorse Family Medicine

Name:_____ **Birth Date:**_____

Primary Objective of Your Appointment Today?

_____

_____

Chronic Medical Problems:

_____

_____

_____

_____

_____

_____

Medications:

Name Strength X/day

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies:

Medication Reaction

_____

_____

_____

Immunizations:

Last Tetanus:_____

Pneumonia: _____ Flu: _____

Past Surgeries:

Name Surgery Month/Year

_____

_____

_____

_____

Past Diagnostic Procedures (colonoscopy/US/MRI/Ct Scan/etc):

Name Procedure/Findings Month/Year

_____

_____

_____

_____

_____

Family History:

(if deceased, manner/age of death)

Dad: _____

Mom: _____

Siblings: _____

_____

_____

Other: _____

Social History:

Employment: _____

Marital Status: _____

Religious preference: _____

Alcohol: Y / N

Type_____

Quantity per week _____

Tobacco: Y / N

Type: _____

If history, year quit: _____

Caffeine Use: Y / N

Illicit Drugs: _____

Hobbies:_____

_____

_____

Would you like to discuss Advanced Directives? Yes / No