CURRENT HEALTH PROBLEM

NAME: _____ DATE: _____

PRIMARY CONCERN: _____

_____

SECONDARY CONCERN: _____

OTHER DOCTORS SEEN: _____

HEALTH HISTORY

Please indicate if you are here for care because of: ☐ an on the job injury ☐ an auto accident ☐ home injury

Date injured	Insurance company	Attorney's name (if any)	Attorney's address

Have you ever had any falls, auto accidents, or injuries?

☐ Yes Please describe
☐ No

MONTH, YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY

Have you ever had surgery?

☐ Yes Please explain.
☐ No

MONTH, YEAR	TYPE OF SURGERY	COMMENTS

Are you presently taking medication?

☐ Yes Please list.
☐ No

NAME OF DRUG	DOSES PER DAY	LENGTH OF TIME TAKING

ALLERGIES _____ OCA _____

DOCTOR NOTES

_____

_____

_____

_____

_____

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