OURFAMI LYDOCT OR
Dr. Jeffrey B. Taylor
NEW/ESTABLISHED PATIENT HISTORY

Name: DOB: Date:

Current Complaints:

Medication Allergies: (list or Write none)

Alcohol: No/Yes Social :1 Daily |:| Smoking: No/Yes Pack per Day: Quit: / /

Immunization History: (include dates if possible)
Adults: Tetanus: / /_ Pneumonia: ,1 /_ Flu: / /_

Other:

Children: (list)

Previous Surgeries: {example. Tonsillectomy (date)}

Health Maintenance:
Papsmear_/ / Mammogram / / Dexa Bone Scan / / Colonoscopy / /

Medical History: {examp[e. High Blood Pressure}

Family History:
Heart Disease Heart Attack Diabetes Stroke Depression Cancer (list)

Medication List:
1.
2.
3.
4
5

Hpswrish

DO YOU CONSENT TO TREATMENT ADVISED BY DRJEFF TAYLOR WHICH MAY INCLUDE INJECTIONS, BLOOD WITHDRAWLS, APPROPRIATE EXAMINATIONS, OR OTHER PROCEDURES AFTER VERBAL EXPLANATION?
YES NO

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT IN ORDER TO PROVIDE TREATMENT?

SIGNATURE DATE