Lowry Medical Clinic

To be filled out at each visit…

Date: _____ Patient Name: _____

What's the reason for your visit to LMC today? _____

Past medical history and active problems: (for example: diabetes, high blood pressure, cancer, stroke, heart disease, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Past surgeries or significant procedures: (for example: recent heart catheterizations, knee, cataract,

etc.) _____

Do you drink alcohol? Yes No (circle one) If yes, how much? _____

Do you use tobacco? Yes No (circle one) If yes, what kind? _____

If cigarettes, how many packs *AVERAGE* per day during the time that you smoked or are still smoking?

_____

Family History:

Mother: Alive: age _____ medical problems: _____ or

Deceased: age _____ died of: _____

Father: Alive: age _____ medical problems: _____ or

Deceased: age _____ died of: _____

Have you seen another physician since your last visit with Dr. Lowry? Yes No (circle one) If yes, did that physician change or add to the medication Dr. Lowry had you on? Changed Added on (circle one)

Did you bring your medications with you? Yes No (circle one)

List *EVERY* medication that you take presently: