CLERMONT INTERNAL & COSMETIC MEDICINE

A Patient-Centered Holistic and Cosmetic Care Center

GENERAL MEDICAL HISTORY

What is the reason for your visit with CICM?_____

How would you rate your general health? ☐Excellent ☐Good ☐Fair ☐ Poor

Do you have any ALLERGIES or REACTIONS to any MEDICATIONS? ☐Yes ☐No

If yes, please list the MEDICATIONS to which you are allergic and specify the REACTIONS:

1)_____ 3)_____

2)_____ 4)_____

SURGICAL HISTORY: Please list ANY and ALL prior surgeries (including as a child) and provide dates.

_____

_____

Do you see any other doctors? If yes, please list their names and specialty:

_____

_____

PERSONAL MEDICAL HISTORY: Please indicate all medical problems that you HAVE Or HAD

_____

_____

_____

MEDICATIONS: Please list ALL medications that you are taking, INCLUDING over the counter medications.

1)_____ 5)_____

2)_____6)_____

3)_____7)_____

4)_____8)_____

Preferred Pharmacy/Address:_____