PREMIERE MEDICAL CENTER · 4418 Vineland Ave · Suite 102 · Toluca Lake · CA · 91602 · Phone · (818) 842-7145 · www.pmcburbank.com ·

INFORMATION FOR YOUR DOCTOR

General

Last Name:_____ First:_____ M.I.:_____

Date of Birth: _____/_____/_____ Age: _____ Sex: _____

What is the main reason for visiting us today? _____

How did you hear about us? *Doctor* *Friend* *Family Member* *Internet* *Other* _____

By whom were you referred? *(if applicable)* _____

Medical History

List **all medical problems**:_____

_____

_____

List **all medications** you are taking: _____

_____

_____

List **all herbal, naturopathic, and homeopathic medications/supplements** you are taking: _____

_____

List **all drug allergies** (include name of medication and reaction): _____

_____

When was your last physical examination? _____

Have you ever been admitted to the hospital? _____ If so, please list the reason(s) and the date(s):_____

_____

***For women*:** When was your last mammogram? _____ Pap smear? _____

Social History

What is your marital status? (Circle): Single Married Domestic Partner Divorced/Widowed Spouse's Name:_____

Do you have any children? _____ If so, how many? _____Boys _____Girls
Y/N # #

If your parents are not living, what was the cause of death(s)? _____

Do you drink alcohol? Never Rarely Socially Daily

How often do you exercise? Never A few times a month Once a week More than once a week

Do you use tobacco products? Yes No If yes, which products? _____ How many times per day?____

Is there any other information that you feel necessary to tell us? _____

_____

Authorization

I hereby authorize whatever services are deemed necessary during my appointment. I agree to assume financial responsibility for ALL services provided.

_____ _____
Signature *Date*