

**ALLISON LINQUIST, MD PC  
MEDICAL HISTORY**

Patient name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Reason(s) for visit today:

Treatment used previously for condition:

- 1.) \_\_\_\_\_
- 2.) \_\_\_\_\_
- 3.) \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Dr. Linquist will try to address as many concerns as time allows, however, an additional appointment may be necessary.

Please list any prescription medications you are regularly taking:

- 1.) \_\_\_\_\_
- 2.) \_\_\_\_\_
- 3.) \_\_\_\_\_

- 4.) \_\_\_\_\_
- 5.) \_\_\_\_\_
- 6.) \_\_\_\_\_

Please list any nonprescription medications you are regularly taking:

- 1.) \_\_\_\_\_
- 2.) \_\_\_\_\_

- 3.) \_\_\_\_\_
- 4.) \_\_\_\_\_

Please list any allergies to medications:

- 1.) \_\_\_\_\_
- 2.) \_\_\_\_\_

- 3.) \_\_\_\_\_
- 4.) \_\_\_\_\_

Please list any environmental or skin allergies:

- 1.) \_\_\_\_\_
- 2.) \_\_\_\_\_

- 3.) \_\_\_\_\_
- 4.) \_\_\_\_\_

Please describe any medical problems you checked "yes" to on the "Review of Systems" form, or any other medical issues you have that were not listed:

- 1.) \_\_\_\_\_
- 2.) \_\_\_\_\_
- 3.) \_\_\_\_\_
- 4.) \_\_\_\_\_

- 5.) \_\_\_\_\_
- 6.) \_\_\_\_\_
- 7.) \_\_\_\_\_
- 8.) \_\_\_\_\_

Please list prior surgeries with approximate date of procedure:

- 1.) \_\_\_\_\_
- 2.) \_\_\_\_\_
- 3.) \_\_\_\_\_

- Date: \_\_\_\_\_
- Date: \_\_\_\_\_
- Date: \_\_\_\_\_

We appreciate your time and effort in completing these forms. The information will help us treat you safely and effectively.