

**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.