Glacier Medical Associates

Welcome to Glacier Medical Associates. Our goal is to provide you with the safest and best medical care possible. Your doctor/nurse practitioner will need to know your medical background. Please complete the following. This information will remain strictly confidential in your medical record.

Please list any <u>current medical conditions</u> you may have such as asthma, diabetes, high blood pressure, arthritis, persistent pains, depression.

Condition	Duration

List any <u>hospitalizations</u>, surgeries, or pregnancies.

Condition	Date/Location

List all medications you take on a regular schedule, including herbal and vitamins, oral contraceptive etc..

Medication/Dosage	Date Begun

List any DRUG ALLERGIES.

Drug	Type of reaction

Tobacco use? No____ Yes____ Amount:____pack per day How Long?____

Your <u>FAMILY'S HEALTH HISTORY</u>: i.e. diabetes, asthma, heart/lung disease, stroke, cancer, alcoholism etc..

Mother's Health History:____

Father's Health History:____

Sibling's Health History:____

Aunt's/Uncle's:____

Grandparent's:____

Children's:____

Your <u>CURRENT HEALTH CONCERN</u>:____

YOUR NAME:________________________________ TODAY'S DATE:_____/_____/20_____