Name **Date**

1. **Reason for visit / main concern:**
2. **Describe the problem:**
3. **History of the problem:**

   When did it start? What makes it better or worse?

   Location of pain, character, still present?

4. **Other symptoms:**
5. **Ever see a doctor or had tests done for this problem?**
6. **Current medical problems:**

   Present medications:

   Recent hospitalizations:

   Allergies:

   Primary care provider:

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