Interval History Information for Dr. Maria Ona

Patient Name: ________________________ **DOB**: __________ **Sex**: M/F

Race: ____________ **Ethnicity**: ______________ **Language**: ______________

Date Completed: ____________ **Completed by**: ______________________

Medication Allergies: No: ___ Yes: ___ (explain below)

1: ________________________________ 2: ________________________________
(Medication) (Reaction) (Medication) (Reaction)

Non-Medication Allergies: None: ____ Yes: ______________________

Vaccine Reactions: None: _____ Yes: ______________________

Current/Chronic Medications:

1. ______________________
(Medication)
____
(Dose) (Date Started)

3. ______________________
(Medication)
____
(Dose) (Date Started)

2. ______________________
(Medication)
____
(Dose) (Dose Started)

4. ______________________
(Medication)
____
(Dose) (Dose Started)

Problem List:

1. ______________________
(Diagnosis) (Date(s))
Details:

3. ______________________
(Diagnosis) (Date(s))
Details:

2. ______________________
(Diagnosis) (Date(s))
Details:

4. ______________________
(Diagnosis) (Date(s))
Details:

Pertinent Past Medical History (check if Yes)

____ Serious Injuries (__________________)

____ Surgeries (__________________)

_____ Hospitalizations (________________)

Pertinent Family Medical History:

____

____

Pertinent Social History:

____

Other Pertinent Information (Referrals, Labs, etc.):