

Patient Diagnostic History and Medication Form:

ID # _____
For Internal Use

Date: _____

Name: _____ Date of Birth: _____ (M/D/Y) Gender Identity: _____

Please list All Primary Diagnosis that you have been given over the past 3 years:

- | | | |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

Please list the Medications that you have been given for these diagnosis over the past 3 years:	Corresponding # from above Diagnosis List	Please report the effectiveness of the medical treatment for each medication you received in the past 3 years:	Please list any Adverse Reactions or Side Effects you experienced while taking each Medication (cont. on back if needed):
Medication:	Diagnosis #	Very Effective —————> Not Effective	Adverse Effects

_____	_____	10 9 8 7 6 5 4 3 2 1	_____
_____	_____	10 9 8 7 6 5 4 3 2 1	_____
_____	_____	10 9 8 7 6 5 4 3 2 1	_____
_____	_____	10 9 8 7 6 5 4 3 2 1	_____
_____	_____	10 9 8 7 6 5 4 3 2 1	_____
_____	_____	10 9 8 7 6 5 4 3 2 1	_____
_____	_____	10 9 8 7 6 5 4 3 2 1	_____
_____	_____	10 9 8 7 6 5 4 3 2 1	_____
_____	_____	10 9 8 7 6 5 4 3 2 1	_____
_____	_____	10 9 8 7 6 5 4 3 2 1	_____