



Patient Name \_\_\_\_\_

Today's Date \_\_\_\_\_

MEDICAL HISTORY				
Hospital visits since last office visit/reason	Facility	Attending physician	Date of hospital visit	Past surgeries (include date and description of any complications)

ALLERGY LIST	
Allergies	Type of reaction

MEDICATION LIST					
if noted elsewhere in chart, indicate location: _____					
Herbals, supplements, OTC drugs, substances of abuse	Date started	Date discontinued	Rx meds, dose, frequency, route	Date started	Date discontinued

PROBLEM LIST				
Chronic problems	Date added	Managing physician (if other)	Date updated	Initial

Patient Name \_\_\_\_\_

Today's Date \_\_\_\_\_

<b>PROBLEM LIST</b> <small>continued</small>				
Acute problems (R=resolved)	Date added	Managing physician (if other)	Date updated	Initial

<b>OTHER PHYSICIANS AND PROVIDERS OF CARE</b> this documentation not required for IPPE		
Name & specialty/provider type	Type of care	Date discontinued

➔ Physician/other provider sign here to indicate review/notation of pertinent history: \_\_\_\_\_