Initial Outpatient Assessment and History Form

Please complete all sections as accurately as possible. This form will be kept confidential as part of your medical record.

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1. Patient Demographics

Full Name:		Date of Birth (MM/DD/YYYY):	
Phone Number:		Today's Date:	
Street Address:			
Emergency Contact:		Emergency Phone:	

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2. Reason for Visit

What is the main reason for your visit today?

How long have you been experiencing these symptoms?

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3. Vital Signs (Clinical Use Only)

Blood Pressure:		Heart Rate (bpm):		Temp (Â°F):	
Weight (lbs):		Height:		SpO2 (%):	

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4. Past Medical History

Please list any current or past medical conditions (e.g., High Blood Pressure, Diabetes, Asthma):

1.
2.
3.
4.

Please list any previous surgeries and the approximate years they were performed:

Surgery/Procedure	Year

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5. Current Medications and Allergies

Please list all current prescription medications, over-the-counter drugs, and supplements:

Medication Name	Dosage / Frequency

Please list any known drug, food, or environmental allergies and your reactions:

Allergen	Reaction

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6. Social and Family History

Occupation:		Tobacco Use (Yes/No/Former):	
Alcohol Use (Weekly frequency):		Exercise (Days per week):	

Family Medical History (Please list major health conditions of parents or siblings):

Father:	
Mother:	
Sibling(s):	

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7. Signatures

By signing below, I certify that the above information is true and correct to the best of my knowledge.

Patient Signature (Write name):		Date:	
Provider Signature:		Date:	