Trinity Health
IHA Medical Group

PATIENT INFORMATION FOR PHYSICAL EXAM

PE

Name: _____ **Date of Birth** ____/____/____

Please list your current medications, dose and how often you take them.

Medication	Dose (mg)	Frequency Taken	Reason Taken	Please **Refill**

Have you experienced an allergic reaction to any medications or latex? **YES** **NO**

Do you need to update any new pertinent family medical history that may be helpful for treatment today? **YES** **NO**

Health Risk factors: *Do You?*	YES	NO		YES	NO
Smoke? cigarettes/day _____	☐	☐	Consume Alcohol? drinks/week _____	☐	☐