

**MEDICAL HISTORY**

<b>Name:</b>	<b>Date of Birth:</b>
<b>Address:</b>	<b>Phone:</b>

<b>Pharmacy Name:</b>	<b>Location:</b>
<b>Phone Number:</b>	<b>Primary Care Physician:</b>

Please list any **ALLERGIES:**


Please list **ALL Medications** you are taking currently - include dosage and how you take it


Please list **ALL Medical Problems** you are treated for by any other physician


Please list any **Surgery** you have had


I give my permission for Valdosta Psychiatric Associates, LLC staff to contact me pharmacy with questions regarding my past and present medications. They will be calling for information regarding my ongoing treatment.

\_\_\_\_\_  
(Patient or Legal Guardian Signature)

\_\_\_\_\_  
(Date)