ORANGE FAMILY PHYSICIANS
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PLEASE TAKE A MOMENT AND COMPLETE THE FOLLOWING:

NAME: _____ DATE OF BIRTH: _____

CURRENT MEDICATIONS: Please list name of med, strength, and how you take it

ALLERGIES:

ALL CURRENT MEDICAL DIAGNOSES: Please list approximate year that you were diagnosed.

SPECIALISTS YOU ARE CURRENTLY SEEING:

SIGNIFICANT FAMILY HISTORY OF ILLNESS:

_____ _____
Patient/Parent/Legal Representative Signature Date

Updated 2/2020