Gateway Medical

# New Patient Medical History Form

Date: _____

Patient Name: _____DOB: (mm/dd/yy)_____

MEDICATION LIST (Use seperate page if needed):

*Please bring all of your current medication bottles with you to your first appointment

| MEDICATION | DOSE | TIME PER DAY | MEDICATION | DOSE | TIMES PER DAY |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

ALLERGIES/SIDE EFFECTS:

| MEDICATION ALLERGY | REACTION/SIDE EFFECTS |
|---|---|
| | |
| | |
| | |

PHARMACY

Name _____Phone _____Fax #_____

Address: _____

Name: _____ DOB:_____