Patient Diagnostic History and Medication Form:

ID # ________
For Internal Use

Date: ________________

Name: ____ Date of Birth: ______________ (M/D/Y) Sex: M / F

Please list All Primary Diagnosis that you have been given over the past 3 years:

1. ________________________ 4. ________________________ 7. ________________________
2. ________________________ 5. ________________________ 8. ________________________
3. ________________________ 6. ________________________ 9. ________________________

Please list the **Medications** that **you have been given** for these diagnosis over the past 3 years:	Corresponding # from above Diagnosis List	Please report the **effectiveness** of the **medical treatment** for each medication you received in the past 3 years:	Please list any **Adverse Reactions** or **Side Effects you experienced** while taking each Medication (cont. on back if needed):
Medication:	**Diagnosis #**	**Very Effective → Not Effective**	**Adverse Effects**
________________________	__________	10 9 8 7 6 5 4 3 2 1	________________________
________________________	__________	10 9 8 7 6 5 4 3 2 1	________________________
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Information will be used for Statistical Purposes in a Strictly Confidential Manner