Date_____

My PCP Member Profile For	
Name	
Date of Birth	

My Preferred Contact Information	
Telephone	
Email	
Address	
Pharmacy	

My Allergies		
	Medications	Food
What?		
What happens if you are exposed?		

My Medications (Prescription and Over- The -Counter)		
Name	Strength	How often do you take it

My Supplements		
Name	Strength	How often do you take it

My Medical History		
Medical Conditions	When Did It Start	Details

My Surgery History			
Type of Surgery	When	Who was surgeon	Details

My Family History			
	Alive	Deceased	Medical Conditions
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Other			

My Preventative Exams	
What	When
Most recent labs	
Colonoscopy	
Mammogram	
Bone Density Test	
Stress Test	
Sleep Study	
Pap Smear	

My Immunization History	
	When
Tetanus/Tdap	
Flu	
Pneumonia (Pneumovax, Prevnar)	
Shingles (Zostavax)	

Who should we contact for your prior records?	
Name	
Telephone	
Fax	
Address	