



Wasilla Medical Clinic
1700 E. Parks Hwy., #200
Wasilla, AK 99654
907-373-6055

Medical History

Patient Information

Patient Name: _____ Sex: M F DOB: ___/___/___

Primary Care Physician: _____

Allergies: _____

Current Medications and/or Supplements/Vitamins: _____

Medical History (list all past and current medical conditions):

Surgical History (list all surgeries): _____

Social History

Tobacco Use: No Yes, _____ packs/day for _____ years Quit: if so, when? _____

Alcohol Use: Never Occasional Daily Quit: if so, when? _____

Recreational Drug Use: No Yes Quit: if so, when? _____

Do you live with someone who uses recreational drugs? No Yes

Traveled Abroad? No Yes: if so, location: _____ Year: _____

Family History

Mother: Deceased Diabetes Cancer Hypertension Coronary Heart Disease Other

Father: Deceased Diabetes Cancer Hypertension Coronary Heart Disease Other

Sibling(s): Deceased Diabetes Cancer Hypertension Coronary Heart Disease Other

Notes: _____

Preferred Pharmacy: _____