BRYNNA CONNOR, M.D.

Thank you for trusting us with your health. Please take a moment to complete this patient history information. We are glad you are here! - Dr. Connor

Name:

Date of Birth:

Mailing Address:

Phone Number:

Email Address:

List all Medications AND Supplements that you are currently taking:

List any Medication Allergies & Reaction:

Do you have any of these medical conditions?

Heart Disease	PMS/Menopause	Hearing Problems	Depression/Anxiety
Cancer	High Cholesterol	Asthma	Insomnia
Ulcers/Colitis	High Blood Pressure	Lung Problems	Seizures
Diabetes	Arthritis	Thyroid Problems	Gluten Intolerance
Sinus Problems	Stroke	Kidney Problems	Heartburn/Reflux
Seasonal Allergies	Headaches	Liver Problems	Anemia
Tonsillitis	Intestinal Problems		

Social History:

Do you smoke? If so, how many packs per day?
Do you drink alcohol? How many drinks per week? Do you drink coffee/tea?
Do you exercise? How much?

List any family history of medical Issues:

Mother:

Father:

Brother/s:

Sister/s:

Female gynecological history:

How many times have you been pregnant?

Date of last Pap smear:

Have you ever had an abnormal pap smear? If so, when?

Date of last mammogram:

By signing below, I hereby certify to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate. I have been offered the privacy policies of the practice of Brynna Connor, M.D.

*NOTE: Brynna Connor, M.D. is a medical practice that truly values your time. We do not double book appointments, and we block the dedicated time needed for your appointment. We kindly ask that if you need to reschedule your appointment, that you do so at least 24 hours in advance, or we will charge the late cancellation fee to the credit card we have on file for you.

Patient/Legal Guardian Signature:

Date: