Medical Forms Writing TEST

Instructions: Fill in the form below with YOUR personal information. When asked: "Reason for visit?" – please describe an illness that you have had for 3 days. You can pick any symptoms you want to describe. Remember - this is a TEST – please do it by yourself.

Family Name:_____ Middle Initial: _____

Given Name:_____ Phone: _____

Email Address: _____

Street Address: _____ Province:_____

City: _____ Postal Code: _____

DOB (MM/DD/YYYY): _____/_____/_____

Gender: Male Female Other

Marital Status:

Married Divorced Single Widow Separated

Reason for your visit today:

Do you have any allergies? YES NO

If yes, describe: _____

Do you smoke? YES NO

If yes, how many cigarettes per day? _____

Do you drink coffee? YES NO

If yes, how many cups per day? _____

Name of Family Doctor:_____

Your Medication

Name of Medication	Daily Dosage of Pills

Your Surgery or Procedures

Name of Surgery	Year of Surgery

Your Medical History – do you have any of the following illnesses?

Name of Illness	YES	NO
Arthritis		
Asthma		
Cancer		
Depression		
Diabetes		
Eye Problems		
High Blood Pressure		
High Cholesterol		
Heart Disease		
Kidney Disease		
Liver Disease		
Stroke		