



**5325 W. UNIVERSITY
MCKINNEY, TX 75071
TEL: 214-592-8188
FAX: 915-206-2822**

Patient Name: _____

Date of Birth: _____

Past Medical History (Diagnoses/Problems):

Past Surgical History:

Drug Allergies:

Smoker: YES/ NO/ FORMER

Family History:

Medications (Or give medications or a list to the receptionist):

