*Genesis Family Care, P.A.*
*Elizabeth Alvarez, M.D.*

Name: _____ _____
Last First
DOB: _____ Age: _____

Medications: _____ _____
_____ _____
_____ _____
_____ _____

Allergies: _____ _____
_____ _____
_____ _____

Please mark any illnesses you have or have had:

___High blood pressure ___Diabetes ___Thyroid disease ___Asthma
___Atrial Fibrillation ___Stroke ___TIA ___ Seizure
___Heart Failure ___Heart Attack ___Glaucoma ___Depression
___Pacemaker ___Gastritis ___Stomach ulcers ___Pneumonia
___Rheumatoid Arthritis ___Irritable Bowel Syndrome ___ Cancer
___Other: please list here _____

Please list all surgeries: (type and year)

_____ _____ _____
_____ _____ _____
_____ _____ _____

**Family History:**

___High blood pressure ___Diabetes ___Thyroid disease ___Asthma
___Atrial Fibrillation ___Stroke ___TIA ___ Seizure
___Heart Failure ___Heart Attack ___Glaucoma ___Depression
___Pacemaker ___Gastritis ___Stomach ulcers ___Pneumonia
___Rheumatoid Arthritis ___Irritable Bowel Syndrome ___ Cancer
___Other: please list here _____