PROBLEM LIST / MEDICATION LIST

Patient Name:		Date:
ALLERGIES:	**REACTION:**	PCP:
		Advance Directive: Yes No In Chart ? Yes No
		Power of Attorney: Yes No In Chart ? Yes No
		Tobacco Use: / Alcohol Use:
		Drug Use:

Prob #	Date Onset	**Significant Acute & Chronic Conditions (Including Surgical Procedures)**	Date Resolved

Prob #	**Medication(s)**	**Dosage/ Date**	**Date Start**	**Date Stop**	**Refills**						