Columbia University Medical Center

In affiliation with
NewYork-Presbyterian Hospital

FOLLOW UP PATIENT HISTORY FORM

1. **NAME:** _____
2. **D.O.B.:**_____
3. **DATE OF VISIT:**_____
4. **PHARMACY INFORMATION** (Name, address, telephone number): _____
5. **MEDICATION LIST** (Please include name of medication, dose and how much often you take the medication.)

Name of Medication	Dose/Strength	How Often Taken

6. **PLEASE LIST ALL ALLEGIES** (Drug, food, etc.)

Allergy	Reaction