PATIENT MEDICAL HISTORY

DATE:____________________

NAME:____________________________________DATE OF BIRTH:_____________

ALLERGIES:

1. ____
2. ____
3. ____
4. ____
5. ____

DO YOU SMOKE?___________________PACKS PER DAY_____________________

DO YOU DRINK?____________________HOW OFTEN_______________________

PAST MEDICAL HISTORY:

(Please list your significant illnesses and when they were diagnosed)

1. ____
2. ____
3. ____
4. ____
5. ____

PREVIOUS SURGERY:

(Please provide approximate date)

1. ____
2. ____
3. ____
4. ____
5. ____

FAMILY HISTORY

(Please list any significant illnesses of your grandparents, parents, siblings and children)

1. ____
2. ____
3. ____
4. ____
5. ____

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