

PATIENT HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Medication:	Name of Medicine	Dose	Prescribed by
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

Allergies: \_\_\_\_\_

Surgery/ Procedure:	Type of Surgery/Procedure:	Date	Surgeon's Name
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

FAMILY MEDICAL HISTORY

Has any family member been diagnosed with the any of the following medical conditions? If yes, state relation to patient:

Yes  No Cancer: \_\_\_\_\_  Yes  No Stroke: \_\_\_\_\_  
 Yes  No Diabetes: \_\_\_\_\_  Yes  No Bleeding Disorder: \_\_\_\_\_  
 Yes  No Heart Disease: \_\_\_\_\_ Other: \_\_\_\_\_

PAST MEDICAL HISTORY, PERSONAL (Check ALL previous illnesses or conditions below.)

Heart  Lung  Thyroid  Diabetes  
 BP  Liver  Freq. Infections  Psychological  
 Circulation  Kidney/urine  HIV/AIDS  Seizure  
 Stroke  Bleeding  Other: \_\_\_\_\_

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