Name: ________________ Date of Birth: ________ Today's Date: ________

- **PAST MEDICAL HISTORY:**

PROBLEMS:

____

____

ALLERGIES:

____

____

SURGERIES *(LIST SURGERIES & DATES)*:

____

____

HOSPITALIZATIONS:

____

____

- **CURRENT MEDICATIONS:**

1. ______________ 2. ______________

3. ______________ 4. ______________

5. ______________ 6. ______________

- **FAMILY HISTORY:**

(Patient family history including, Asthma, Diabetes, Stroke, Heart Disease, Liver Disease, Kidney Disease, Thyroid Disease, High Blood Pressure, Cancer and/or Psychiatric Disease. Etc.)

RELATION:	NO.:	BIRTH YR:	DEATH AGE:	HEALTH PROMBLEM:
Mother	1			
Father	1			
Sister(s)				
Brother(s)				
Daughter(s)				
Son(s)				

- **SOCIAL HISTORY:**

SEXUALLY ACTIVE:	[ ] Yes [ ] No		
TOBACCO:	[ ] Yes [ ] No	[ ] Cigarette [ ] Cigar [ ] Pipe [ ]Chew	[ ]Per Day
ALCOHOL	[ ] Yes [ ] No	[ ] Beer [ ] Wine [ ] Mixed [ ]Liquor	[ ]Per Day
IV STREET DRUGS:	[ ] Current [ ] Past [ ] No		
RECREATIONAL DRU(	[ ] Current [ ] Past [ ] No		