MEDICAL HISTORY FORM – Date: ___ / ___ / _____

Pt. Name: _____DOB: __ / __ / ____ Age: _____

Referring Physician:_____ Phone:_____

Family Physician:_____ Phone:_____

Reason for Visit:_____

Allergies:

Medications:

Medical History (including surgeries)

Please list any significant medical problems of your family members:

Parents:_____ Grandparents: _____

Children:_____ Brothers/Sisters: _____

Occupation:_____

Do you smoke? ❑ No ❑ Yes How much? _____

Do you drink alcohol? ❑ Never ❑ Occasionally ❑ Every week ❑ Every day

T ____P___ R___ BP___/___Wt____kg. Ht___in. Recorder_____Date:_____

Physical Exam Notes