

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