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# MEDICAL HISTORY FORM

**PATIENT NAME:** _____ **DOB:**_____

**CURRENT MEDICATIONS AND DOSAGES:**

_____

_____

**PAST MEDICAL HISTORY:**

_____

_____

_____

**ALLERGIES TO MEDICATIONS:** _____

**PAST SURGICAL HISTORY:**

_____

_____

**FAMILY HISTORY:**

_____

_____

_____

**SOCIAL HISTORY:**

**ALCOHOL: NO/YES. IF YES, DRINK PER WEEK:** _____

**TOBACCO: NO/YES. IF YES, CIGARETTES PER DAY:** _____

**DRUG USE: NO/YES. IF YES, TYPE OF DRUG[S] USED:** _____

**OCCUPATION:** _____