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MEDICAL HISTORY FORM

PATIENT NAME: ____**DOB:**____________________

CURRENT MEDICATIONS AND DOSAGES:

____

____

PAST MEDICAL HISTORY:

____

____

____

ALLERGIES TO MEDICATIONS: ____

PAST SURGICAL HISTORY:

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FAMILY HISTORY:

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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: ____