PATIENT MEDICAL HISTORY

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| *Name:* | | | | | *Birth date:* | | | | | | | | | | | |
| **PAST MEDICAL HISTORY** | | | | | | | | | | | | | | | | |
| **Childhood Illnesses** | Diphtheria | |  | | | Measles | |  | Mumps | | | |  | Rheumatic Fever | |  |
| Chicken Pox | | | | |  | Scarlet Fever | | | | |  |  | | |  |
| **Past Surgeries**  (list operations, dates,  & complications ) |  | | | | | | | | | | | | | | | |
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| **Serious Adult Illnesses & Hospitalizations**  (list dates &  complications) |  | | | | | | | | | | | | | | | |
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| **Chronic Medical Problems** | Diabetes |  | | Hypertension | | | | | |  | Ulcers | | |  | Emphysema |  |
| Cancer |  | | Heart Disease | | | | | |  | Stroke | | |  | Tuberculosis |  |
| Asthma |  | | Kidney Stones | | | | | |  | Gout | | |  |  |  |
| Stroke |  | | Kidney Disease | | | | | |  |  | | |  |  |  |
| **Injury History**  (list dates and complications ) | Fractures? | | | | | | | | | | | | | | | |
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| Loss of consciousness? | | | | | | | | | | | | | | | |
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| **Allergies**  (list reactions) | Medications | | | | | | | | | | | | | | | |
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| Other | | | | | | | | | | | | | | | |
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| **Current Medications**  (list all over-the counter meds and dosages) |  | | | | | | | | | | | | | | | |
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| **FAMILY HISTORY** | | | | | | | | | | | |
| RELATIVE | | PRESENT  AGE | | PRESENT  HEALTH | | | | | | AGE & CAUSE OF DEATH | |
| Father | |  | |  | | | | | |  | |
| Mother | |  | |  | | | | | |  | |
| Grandparents | |  | |  | | | | | |  | |
| Sibling | |  | |  | | | | | |  | |
| Children | |  | |  | | | | | |  | |
|  | |  | |  | | | | | |  | |
| **SOCIAL HISTORY** | | | | | | | | | | | |
| Birth Date | | | | | | Birth Place | | | | | |
| Marital History | | | | | | Occupation | | | | | |
| Turmoil (financial, emotional, etc) | | | | | | | | | | | |
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| **Exercise &**  **Frequency** | |  | | | | | | | | | |
| Habits | Tobacco | | Yes | |  | | No |  | \_\_\_Packs/day | | Year Quit |
| Alcohol | | Yes | |  | | No |  | \_\_\_Drinks per day/week/month/yr | | |
| Caffeine | | Yes | |  | | No |  | \_\_\_Drinks per day/week/month/yr | | |
| Drugs | | Yes | |  | | No |  | Quit? Type/Frequency | | |
| Other | |  | | | | | | | | |
| **OTHER PERTINENT MEDICAL HISTORY** | | | | | | | | | | | |
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| *Signature: Date:* | | | | | | | | | | | |