

MEDICAL HISTORY

Chart # _____

Date _____

Name of Patient: _____ Gender: _____ DOB: _____

Form Completed By: _____ Relation (if other than Patient) _____

Marital Status: Single Married Partner Separated/Divorced Widowed

List Family Members:

Name	Age	Relation	Health Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Work History:

Are you employed outside the home? _____ Name of Employer _____

Past Medical History: _____ Are Immunizations Up to Date? _____

Are you having any medical problems, if yes, please note below:

Current Medications:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies: _____

List serious injuries:

Past Surgical History:

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