JOHN R PEDROTTY M.D.

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_____
Name_____Age_____Relation_____Health Problems_____
Name_____Age_____Relation_____Health Problems_____
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:

_____

_____

_____