

PAST MEDICAL, FAMILY, AND SOCIAL HISTORY

PATIENT NAME: _____ **DOB:** _____

DRUG ALLERGIES <input type="checkbox"/> YES <input type="checkbox"/> NO - IF YES, LIST NAMES & REACTIONS
MEDICATIONS (RX & OTC) (NAME AND DOSAGE)
PAST MEDICAL HISTORY/ SURGERIES

SOCIAL HISTORY		
MARITAL STATUS: Married Single Widowed Divorced Legally Separated		ALCOHOL: YES NO
OCCUPATION:		DRUGS: YES NO
SMOKING: YES NO Packs Per Day _____	Quit, How long ago _____	CAFFEINE: YES NO
EXERCISE: YES NO		
DIET:		
FAMILY MEDICAL HISTORY		
FATHER:		
MOTHER:		
SIBLINGS:		
GRANDPARENTS:		

I HAVE READ AND REVIEWED THE ABOVE AND HAVE NO CHANGES.

PATIENT SIGNATURE _____ UPDATED _____

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