NAME _____ **DATE OF BIRTH**_____

PAST MEDICAL HISTORY

Operation/Surgery (Names and date of procedure)

1. _____
2. _____
3. _____
4. _____
5. _____

Hospitalizations (Where, reason, date and length of stay)

1. _____
2. _____
3. _____
4. _____
5. _____

Medical Problems (Problem and date diagnosed)

1. _____
2. _____
3. _____
4. _____
5. _____

Social History: (Adults and adolescents)

Do you smoke (check all that apply) Yes ___No___Never___Quit___
If "yes", how many cigarettes per day?_____
How soon after you wake do you smoke?____
If you "Quit", how long ago?_____

Family History (Relation and condition)

_____
_____
_____
_____

Allergies (To medications)

_____
_____

Please bring an updated medication list with you or you may write it on the back of this paper.