PAST MEDICAL HISTORY  Deparation/Surgery (Names and date of procedure)  1	NAME	DATE OF BIRTH
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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)	pperanon/surgery (maines and date of pro-	cedure)
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2	Iospitalizations (Where, reason, date and le	ength of stay)
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Family History (Relation and condition)		
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Allergies (To medications)	Family History (Relation and condition)	
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Please bring an updated medication list with you or you may write it on the back of	Please bring an undated medication list	with you or you may write it on the back of

this paper.