PAST MEDICAL HISTORY: LIST ALL MEDICAL HISTORY IE: DIABETES, HIGH CHOLESTEROL, HIGH BLOOD PRESSURE ETC.
1.
2.
3.
4.
5
6.
7.
8.
9.

SURGERIES : LIST ALL SURGERIES & DATES
1.
2.
3.
4.
5.
6.
7.

MEDICATIONS/NAME	STRENGTH	TAKE	FREQUENCY
EX: LISINOPRIL	***20 MG***	***1 TABLET***	***ONCE A DAY***
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

FAMILY HISTORY				
	AGE	**STATE OF HEALTH**	**AGE AT DEATH**	**CAUSE OF DEATH**
MOTHER				
FATHER				
BROTHER (S)				
SISTER (S)				

PLEASE CHECK THE SUBSTANCE YOU USE AND HOW MUCH YOU USE IT.		PLEASE LIST ALL ALLERGIES TO FOOD OR DRUGS		What Pharmacy would you like to use for Prescriptions?
	Caffeine	1.	5.	
	Tobacco	2.	6.	
	Alcohol	3.	7.	
	Other	4.	8.	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE: _____