MEDICAL HISTORY

Past Medical History

Hospitalizations: (Medical/Surgical) Year Any Complications

_____

_____

_____

_____

_____

Allergies:

_____

_____

_____

Medications: (LEAVE BLANK IF YOU HAVE A MEDICATION LIST)

Name the Drug	**Strength**	**Frequency Taken**
_____	_____	_____
Pharmacy	**Phone Number**	**Address**
_____	_____	_____

Family Medical History: **Age Now or at Death** **Cause of Death** **Any Health Problems, if Alive**

Mother: _____

Father: _____

Social History:

Smoker? Yes ☐ No ☐ If yes, how many packs per day for days/weeks/months/years

Alcohol? Yes ☐ No ☐ If yes, how often? Daily 1-2 times/week 1-2 times/month 1-2 times/year

Recreational/Illicit Drugs? Yes ☐ No ☐

Hearing Impaired? Yes ☐ No ☐ Hearing Aid? Yes ☐ No ☐ Dentures? Yes ☐ No ☐

Are you on a special diet (diabetic, low-sodium, etc.)? Yes ☐ No ☐