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/wks/mnths/yrs.
If No, did you ever smoke and when did you quit? _____

Alcohol, Yes___ No__ If Yes, How often? Daily__ 1-2 times/wk___ 1-2 times/month__ 1-2 times/yr__

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__