

# MEDICAL HISTORY

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

## Social History:

(Please list all information about any smoking and/or drinking history and/or current use amounts, dates started, and date stopped)

Tobacco: \_\_\_\_\_

Alcohol: \_\_\_\_\_

## Family History:

(Please list information about illnesses that run in your family. Include medical illnesses in individual family members. We are most interested in your parents, siblings, and children, but add anything else that you feel is pertinent.)

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## Past Medical History:

(Please list any medical problems you may have such as high blood pressure, elevated cholesterol, ulcer problems, chronic pains, etc....)

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## Past Surgical History:

(Please list any previous surgeries and hospitalizations you may have had.)

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