NAME ______________________________ DATE ____________________

Past Medical/Social/Family History

ONLY NEEDS TO BE COMPLETED FOR NEW PATIENTS TO THE PRACTICE

(circle or write in appropriate response)

PAST MEDICAL HISTORY

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

MEDICATIONS

	medication	dose	frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

PAST SURGICAL HISTORY

1.
2.
3.
4.
5.
6.
7.
8.

MEDICATION ALLERGIES;

	medication	reaction
1.		
2.		
3.		
4.		
5.		
6.		
7.		

FAMILY HISTORY

illness	who?
heart disease	
diabetes	
stroke	
asthma	
colon cancer	
breast cancer	
prostate cancer	
aneurysm	
other	

SOCIAL HISTORY

status:	married	divorced
	single	widow
occupation:		
tobacco use:	yes	no
alcohol:	yes	no
drug use:	yes	no

IMMUNIZATIONS

immunization	date
1. tetanus	
2. pneumonia	
3. shingles	
4. other:	