

# PERSONAL MEDICAL HISTORY



Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex:  Male  Female

Doctor (s) Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_

Current Medical Condition(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Surgeries: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you smoke?  Yes  No

Have you ever smoked?  Yes  No

If yes, how long? \_\_\_\_\_ When did you quit? \_\_\_\_\_

Do you drink alcohol?  Yes  No

How much and how often? \_\_\_\_\_

Do you drink coffee or caffeinated beverages?  Yes  No

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