

PERSONAL MEDICAL HISTORY



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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