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| MEDICAL HISTORY FORM | | | | | | | | | | | | | | | | | | | | |
| All questions contained in this questionnaire are strictly confidential  and will become part of your medical record. | | | | | | | | | | | | | | | | | | | | |
| Name (Last, First, M.I.): | | |  | | | | | | 🞎 M 🞎 F | | | DOB: | |  | | | | | | |
| Marital status: | | 🞎 Single 🞎 Partnered 🞎 Married 🞎 Separated 🞎 Divorced 🞎 Widowed | | | | | | | | | | | | | | | | | | |
| Previous or referring doctor: | | | | |  | | | Date of last physical exam: | | | | | | | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| PERSONAL HEALTH HISTORY | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Childhood illness: | | | 🞎 Measles 🞎 Mumps 🞎 Rubella 🞎 Chickenpox 🞎 Rheumatic Fever 🞎 Polio | | | | | | | | | | | | | | | | | |
| Immunizations and dates: | | | | 🞎 Tetanus | |  | | 🞎 Pneumonia | | | | |  | | | | | | | |
| 🞎 Hepatitis | |  | | 🞎 Chickenpox | | | | |  | | | | | | | |
| 🞎 Influenza | |  | | 🞎 MMR Measles, Mumps, Rubella | | | | | | |  | | | | | |
| List any medical problems that other doctors have diagnosed | | | | | | | | | | | | | | | | | | | | |
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| Surgeries | | | | | | | | | | | | | | | | | | | | |
| Year | Reason | | | | | | | | | | Hospital | | | | | | | | | |
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| Other hospitalizations | | | | | | | | | | | | | | | | | | | | |
| Year | Reason | | | | | | | | | | Hospital | | | | | | | | | |
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| Have you ever had a blood transfusion? | | | | | | | | | | | | | | | | | 🞎 | Yes | 🞎 | No |
|  | | | | | | | | | | | | | | | | | | | | |
| List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers | | | | | | | | | | | | | | | | | | | | |
| Name the Drug | | | | | | | Strength | | | Frequency Taken | | | | | | | | | | |
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| Allergies to medications | | | | | | | | | | | | | | | | | | | | |
| Name the Drug | | | | | | | Reaction You Had | | | | | | | | | | | | | |
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