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.)

Father:_____
Mother:_____
Brother:_____
Sister:_____
Other:_____
_____

Advanced Care Planning Completed: Yes ◯ No ◯

Past Medical History:
(Please list any medical problems you may have such as high blood pressure, elevated cholesterol, ulcer problems, chronic pain, etc….)

_____
_____
_____
_____
_____

Past Surgical History:
(Please list any previous surgeries and hospitalizations you may have had.)

_____
_____
_____
_____