MEDICAL HISTORY

Patient's Name _____ Date _____
Last First Initial

FAMILY HISTORY:

	Age(s)	*Living*	*Deceased*	*Cause*
Mother				
Father				
Brother(s)				
Sister(s)				
Son(s)				
Daughter(s)				

DISEASES:

	Mother	*Father*	*Sister*	*Brother*	*Son*	*Daughter*
Tuberculosis						
Cancer						
Heart Disease						
Epilepsy						
Diabetes						
Kidney Disease						
Others						

PERSONAL HISTORY:

Childhood Diseases

	Yes	*No*
Scarlet Fever		
Mumps		
Measles		
Rheumatic Fever		
Allergies - Drugs		
Allergies - Food		
Tape		
Others		

Illnesses:

	Yes	*No*	*Date(s) of Occurrence & Description*
Eyes			
Ears			
Nose			
Throat			
Breast			
Heart			
Lungs			
Gastro-intestinal			
Neuro-muscular (Epilepsy Fainting Headaches)			
Orthopedic			
Urinary			

LIST ALLERGIES:

1. _____
2. _____
3. _____
4. _____

LIST DRUGS PRESENTLY USING:

1. _____
2. _____
3. _____
4. _____

SURGERIES:

1. _____
2. _____
3. _____
4. _____

	Description	Date(s) of Occurence
1.		
2.		
3.		
4.		

SIGNATURE: _____