PATIENT HISTORY FORM

TODAY'S DATE:____________________ DATE OF LAST PHYSICAL EXAM:____________

LAST NAME:______________________________ FIRST NAME:__________________________

DATE OF BIRTH:__________________________ SMOKER Y N

PAST MEDICAL HISTORY

___Hypertension ___High Cholesterol ___Diabetes ___Thyroid

___Heart Attack ___Stroke ___Colon Cancer ___Breast Cancer

___Other ____

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CURRENT MEDICATIONS : ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

PAST SURGICAL HISTORY:____

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SPECIALISTS (Please list all other physicians seen):___________________________

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