PAST MEDICAL HISTORY

Patient Name:_____

Any Chronic Illnesses: (ie- asthma, ADHD)

_____

Surgeries/Operations: (what and when)

_____

Broken bones? (which and when)

_____

What medication is patient taking now?

_____

Any allergies? Medications: _____
Food: _____
Environmental: _____

Illnesses that run in family?
What? _____ In who? _____
What? _____ In who? _____
What? _____ In who? _____

History of tobacco (cigarette) use? Yes / No If so, how much _____/day

Who lives at home with patient?

_____

Any special custody/guardianship arrangements we should know about?

_____