Name:_____

Past Medical History

Medical Illnesses	Self	Family	Notes
Hepatitis A, B or C			
Diabetes			
Chronic lung disease/Asthma			
Cancer			
Thyroid Problem			
Blood Disorder/Anemia			
Heart trouble/Murmur			
High blood pressure			
Kidney disease			
Bowel trouble/Ulcers			
Skin disorders			
Arthritis			
Seizures			
Strokes			
Headaches			
STD's (GC, Chlamydia, HPV, Herpes			
Emotional/ depression/anxiety			
Other:			

Surgery		Allergies
Year	Procedure	Medications/Reactions

Immunizations	Date	Date