Name_____ Date_____ DOB_____

MEDICATIONS

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ALLERGIES

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TOB/AMT

_____

ALCOHOL/AMT

_____

PAST MEDICAL HISTORY
SURGERY/DATE

_____
_____
_____
_____
_____

FAMILY HISTORY

CANCER-_____
_____
DIABETES_____
_____
HEARTDISEASE_____
_____
OTHER_____
_____
_____
_____
_____

MEMMOGRAM/DATE_____
PAP SMEAR/DATE_____
TETANUS BOOSTER_____
CHEST XRAY_____
TB SKIN TEST_____
COLONOSCOPY_____
PSA_____

CHRONIC/SIGNIFICANT
MEDICAL PROBLEMS

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

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