

Medical History Summary

Name: _____ Born: _____ Date Completed: _____

Family Physician: _____ Physician's Phone # : _____

What month/year did you last smoke tobacco? ____/____ Never

Allergies

Allergen	Date Started	Typical Symptoms & Severity

Medications (List any prescription medications taken in the past 12 months)

Drug Name	Dose	Frequency Taken	Condition Treated	Date First Prescribed	Date of Last Change	How Dosage Changed		
						Increase	Decrease	Stop
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical Conditions, Hospitalizations, Surgeries, Investigations, etc. Include pending tests, surgeries, etc.

Condition	Date	Results

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