

Family Medical History

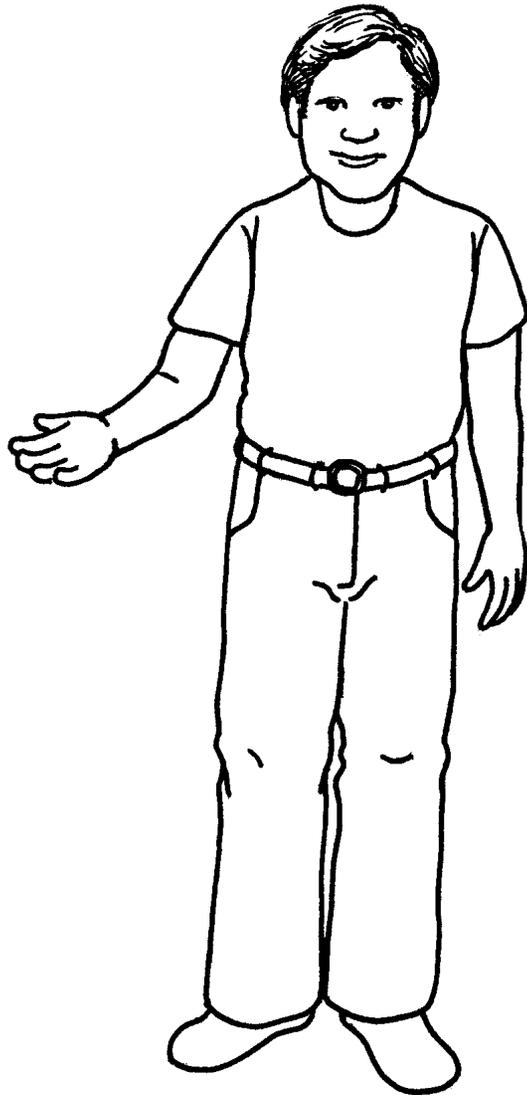
1. Date of last medical exam _____

2. Have you ever been hospitalized for surgery or serious illness?
___ Yes ___ No

If yes,

Date	Reason	Hospital
_____	_____	_____
_____	_____	_____

3. Are you taking any medications?
___ Yes ___ No



Patient Medical History

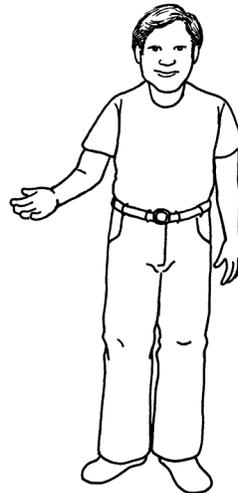
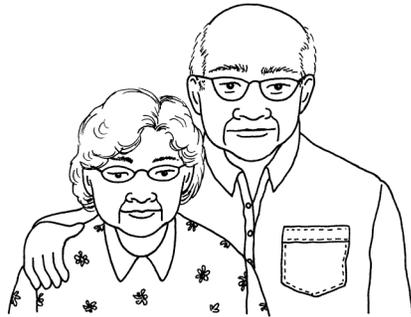
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A clipboard with a paper titled "Family Medical History". The form contains three numbered questions and a table for recording hospitalizations.

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If yes,

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_____	_____	_____
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