



family history



Patient Medical History		
1. Date of last medical exam _____		
2. Have you ever been hospitalized for surgery or serious illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes,	Reason	Hospital
Date		
3. Are you taking any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		

medical history



allergies



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immunization



receptionist



fill in forms