MEDICAL HISTORY

All questions contained in this questionnaire are strictly confidental and will become part of your medical record.

Original Date: Dates Revised:

Name *(Last, Firts, M.I.)*: ☐M ☐F	**DOB:**
Marital Status: ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed	
Previous or Referring Doctor:	**Date of Last Physical Exam:**

PERSONAL HEALTH HISTORY

Childhood Illness: ☐Measles ☐Mumps ☐Rubella ☐Chickenpox ☐Rheumatic Fever		
Immunizations and Dates:	☐Tetanus	☐Pneumonia ☐Polio
	☐Hepatitis	☐Chickenpox
	☐Influenza	☐MMR *Measles,Mumps,Rubella*

List Any Medical Problems That Other Doctors Have Diagnosed

Surgeries

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

Have You Ever Had a Blood Transfusion?	☐Yes ☐No