(DoctorsInRvs) MEDICAL HISTORY (DoctorsInRVs)

NAME_____ **DOB**_____ **SEX: []M []F** **PHYSICIAN**_____ **PHYSICIAN PHONE**_____

NAME OF MEDICATIONS	DOSE	FREQUENCY	STARTED	*DISCONTINUED

Optional Patient ID Information Or Sticker Here

*Record date medication is discontinued and draw a line thru that row.

OTC MEDICATIONS: _____

ALLERGIES (list med/type of reaction/date)

[]Penicillin_____ []Sulfa_____ []Aspirin_____ []Iodine_____ []Codeine_____ []Latex_____

[]_____ []_____ []_____ []_____ []_____ []_____

DIAGNOSES (list date if known)

01-_____ 05-_____ 09-_____

02-_____ 06-_____ 10-_____

03-_____ 07-_____ 11-_____

04-_____ 08-_____ 12-_____

SURGERIES (list date if known)

[]Appendectomy_____ []Cataract_____ []C-Section_____ []Cholecystectomy_____

[]Hemorrhoidectomy_____ []Hysterectomy_____ []Prostate_____ []Coronary Artery Bypass/Stent_____

[]Thyroid_____ []Tonsillectomy_____ []Tubal Ligation_____ []Pacemaker/Defibrillator_____

[]Vasectomy_____ []_____ []_____ []_____

HABITS

SMOKES []No []Yes (cigarettes / cigars / chew / dip) _____Yrs []Quit (date) _____ Prior Smoking Cessation Treatment _____

ALCOHOL []No []Yes (beer / wine / liquor/ whisky / rum / brandy) Amount_____ STREET DRUGS []No []Yes _____

OTHER INFORMATION: _____

_____ _____ _____ _____

Print Physician's Name DIRV License # Physician's Signature Date

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