



Medical History (Part 1)

Please fill out this Medical History Form carefully, and give it to the receptionist.

Patient's Name:

Date:

Address:

Age: Married: Yes No Children: Yes No How many?

Sex / Gender: Male Female U.S. Citizen: Yes No

Height: Feet Inches Weight: Pounds

What medicines do you take?

Do you smoke cigarettes? Yes No

Do you exercise? Yes No

Name of your family doctor:

When was your last visit to the doctor?