**Medical History Form**

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| Name: | DOB: |

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| Medical condition | Date (year) | Medical condition | Date (year) |
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| Surgical procedure | Date (year) | Surgical procedure | Date (year) |
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| Family history –list medical condition for your family members | |
| Mother |  |
| Father |  |
| Siblings |  |
| Others |  |

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| Medication list | |
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| ALLERGIES (meds and reaction) |
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| VACCINATIONS (dates) | | | |
| TD |  | HEP A |  |
| TDAP |  | HEP B |  |
| ZOSTAVAX |  |  |  |
| PNEUMONIA 13 |  | Other |  |
| PNEUMONIA 23 |  |  |  |

Patient signature:

Date: