HFP

Name _____ DOB _____

Pharmacy _____ Phone: _____

Medications you are allergic to: All Other Allergies:

_____ _____

_____ _____

_____ _____

**PAST MEDICAL HISTORY**

Surgery: (type and date) Diagnosis:

_____ _____

_____ _____

_____ _____

_____ _____

**SOCIAL HISTORY**

Do you use any of the following? (Answer yes or no)

Alcohol _____ Tobacco _____ Illegal Drugs _____

**FAMILY HEALTH HISTORY** (Check all that apply)

Diabetes_____ Cancer _____ High Blood Pressure _____ Heart Disease _____ Anemia _____

Other _____

**MEDICATIONS** (prescription and over the counter)

| Medication | Dose | Frequency |
|---|---|---|
| | | |
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