

Peter E. Franklin, M.D.

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## Medical History Form

### Personal Information

Name \_\_\_\_\_ Date: \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex: M F

### Past Medical History

(Please include date and reason)

Surgeries \_\_\_\_\_  
Hospitalizations \_\_\_\_\_  
Other \_\_\_\_\_

### Current Medical Information

Medications \_\_\_\_\_  
Allergies \_\_\_\_\_  
Disease or Illness \_\_\_\_\_

### ***(Female Only)***

Last Menstrual Period \_\_\_\_\_ Last Pap Smear \_\_\_\_\_  
Last Mammogram \_\_\_\_\_

### Family History

(please list any illness or disease)

Mother \_\_\_\_\_  
Father \_\_\_\_\_  
Sisters \_\_\_\_\_  
Brothers \_\_\_\_\_

### Social History

Marital Status S M D W # of Children \_\_\_\_\_  
Occupation \_\_\_\_\_  
Alcohol Use \_\_\_\_\_ Tobacco Use \_\_\_\_\_  
Substance Abuse \_\_\_\_\_