Peter E. Franklin, M.D.

Medical History Form

Personal Information

Date:_____

Name _____

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 _____