**AMANDEEP PAL M.D. PLLC**

**PAST MEDICAL HISTORY FORM**

NAME _____
ADDRESS_____ PHONE_____
_____

DATE _____ DOB_____ AGE_____ SEX_____

EMERGENCY CONTACT _____PHONE_____

RELATIONSHIP TO PATIENT _____

ALLERGIES: _____

BLOOD TYPE IF KNOWN_____

**OTHER PHYSICIANS YOU ARE SEEING:**

**NAME SPECIALITY REASON DATE**

**1) _____**

**2) _____**

**3) _____**

**IMMUNIZATION HISTORY**

| **VACCINE:** | **DATE:** |
|---|---|
| **DPT** | |
| **POLIO VACCINE** | |
| **MMR** | |
| **TETANUS/DIPHTHERIA** | |
| **PPD/TINE TEST** | |
| **FLU VACCINE** | |
| **RUBELLA TITER** | |
| **PNEUMONIA VACCINE** | |

**HISTORY OF PAST ILLNESS:**

**PREVIOUS HOSPITALIZATIONS**

DATE DIAGNOSIS SURGERY HOSPITAL

**FAMILY HISTORY**

| FAMILY MEMBER | AGE | LIVING Y/N | HEALTH STATUS | CAUSE OF DEATH |
|---|---|---|---|---|
| MOTHER | | | | |
| FATHER | | | | |
| SIBLINGS | | | | |

**SOCIAL HISTORY**

MARITAL STATUS / HX OF DOMESTIC ABUSE:

OCCUPATION:

ALCOHOL/ILLICIT DRUGS:

TOBACCO:

COFFEE/CAFFEINE:

EXERCISE:

HOURS SLEEP:

SPECIAL DIET:

OTHER:

**OB HISTORY (WOMEN)**

LMP G P

LAST PAP SMEAR:

MAMMOGRAM:

GYNECOLOGICAL EXAM:

PATIENT SIGNATURE_____

DATE _____