SPRING CITY
Health Centre

817 N East Avenue Waukesha, WI 53186
262-547-3055

PAST MEDICAL, FAMILY, AND SOCIAL HISTORY

PATIENT NAME: _____ **DOB:** _____

DRUG ALLERIES ☐ YES ☐ NO - IF YES, LIST NAMES & REACTIONS
MEDICATIONS (RX & OTC) (NAME AND DOSAGE)
PAST MEDICAL HISTORY/ SURGERIES

SOCIAL HISTORY	
MARITAL STATUS: Married Single Widowed Divorced Legally Separated	**ALCOHOL:** YES NO
OCCUPATION:	**DRUGS:** YES NO
SMOKING: YES NO Packs Per Day ____ Quit, How long ago _____	**CAFFEINE:** YES NO
EXERCISE: YES NO	
DIET:	
FAMILY MEDICAL HISTORY	
FATHER:	
MOTHER:	
SIBLINGS:	
GRANDPARENTS:	

I HAVE READ AND REVIEWED THE ABOVE AND HAVE NO CHANGES.

PATIENT SIGNATURE_____ UPDATED_____

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