Delaware Medical Care Associates, LLC				Patients Name:			
<b>Medical History Form</b>				Date of Birth:			
			ļ	Sex:	Mal	e orFemale	
Primary C	Care Provider:						
Drug Alle	rgies/Sensitivities:						
	y Phone #:						
(Check) YES Past/Present Medical History				Past H	ospitaliz	zations/ Surgeries	Date
120	High Blood Pressure						
	Diabetes						
	Asthma						
	Bronchitis						
	Pneumonia						
	ТВ			Medication List			Date Started
	Hay Fever				Starteu		
Head or Neck Radiation							
	Anxiety						
	Anemia						
		·					
		Immunizat	ion	History		Social History	
Y N Family Member		El- I				☐ Married ☐ Single	
☐ ☐ Cancer (Type)		Flu Immunization		in Married in Shigle			
☐ ☐ Heart Disease				Race/ Ethnicity			
☐ ☐ Diabetes				☐ American Indian/ Alaskan☐ Hawaiian/Pacific Island			
□ □ Stroke		Pneumovax Immunization □Y □N		□N	☐ Black/ African American		
□ □ Depr	If ves, date			☐ White ☐ Hispanic			
	☐ Other Race			October Race			
☐ ☐ Tobacco Usage ☐ ☐ Glaucoma		Occupation:Advance Directive? \( \square\) Yes			П №		
□ □ Bleeding Disease					If Yes, Date:		
Mother	□ Alive, Age					Alaskal/Day II EV	
MUMICI	☐ Deceased, Age			Alcohol/ Drug Us Tobacco Usage		Alcohol/ Drug Use	□ No
						If yes,YRS PPD_	
Father	☐ Alive, Age						<del></del>

Signature: \_\_\_\_\_ Date: \_\_\_\_\_