Robert David Tufft MD

Past Medical History Form

Patient Name_____ Date of Birth_____ Age_____

Past/Current Ongoing Medical Problems

Problem	Date Onset	Therapy to date

Surgery

Surgery Type	Date

Medications

Medication Name	Dosage	Taken___times per day

Suppliments/Vitamins/Herbs

Suppliment	Dosage	Taken____times per day

Allergies

Medications	Inhalants/Other

Habits

Smoke	Current	Former
Drink/day	Current	Former
Drug Use	Current	Former

Social History

Marital Status
Occupation/Job
Exercise Type
Hobbies

Family History

Relationship	Alive/Deceased/Age	Problems/Cause of Death
Father		
Mother		
Siblings #		
Children #		