MEDICAL HISTORY

Donald D. Davenport Jr., D.O.

Name: ____ Date: ___________________________

Reason for visit: ____Refered by: ______________________________

Pharmacy: ____

Past Medical History: (Please list any medical problems you have:

1.______________________________ 2. ______________________________ 3. ______________________________

4. _____________________________ 5. ______________________________ 6.______________________________

7. _____________________________ 8._______________________________ 9.______________________________

Surgical History/Trauma History: (List the operations or injuries you have had, along with the date)

1.______________________________ 2. ______________________________ 3. ______________________________

4. _____________________________ 5. ______________________________ 6.______________________________

Have you or any family members ever had a reaction to anesthesia?___________ Bleeding Problems?______________

Medications: List the medications you are currently taking along with the dosages and reason
(Including vitamins and herbal supplements)

Medication	Dosage and Frequency	Reason
1		
2		
3		
4		
5		
6		
7		
8		
9		

Have you taken the following in the last month? Prednisone______ Coumadin______ Aspirin/Motrin/Naprosyn_________

What meds are you ALLERGIC to? ____
(list medication and the reaction)

Menstrual History: Age of onset ______ Age of Menopause ______ Number of Pregnancies ____ Live births _________

Miscarriages_____ Last menstrual period______Age of first pregnancy_______ Do you take birth control pills__________