EAST CAROLINA MEDICAL ASSOCIATES - Medical & Surgical History

Name: _____, _____ _____ Date: _____
LAST FIRST INITIAL

MEDICATIONS CURRENTLY TAKING Please list any medication you're currently taking or have taken in the last 30 days, prescription or over the counter for any condition:				
Medication	**Reason**	**Dose**	**How often**	**Start Date**

SURGICAL HISTORY		
Surgery/Procedure	**Reason**	**Year**

ALLERGIES (to any medications, foods, or materials of any kind)		
Allergic to:	**Reaction:**	**Start Year:**

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For office use only

Comments:

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