

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. Please fill out every item. It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name _____ First _____ MI _____

Sex Male Female Date of Birth: _____

Name of Primary Care Physician: _____

Pharmacy Preference (include location): _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? ____ Yes ____ No. If yes, please list below:

Name of Medication	Type of Reaction

Have you ever had an allergy blood test? ____ Yes ____ No

Have you ever had an allergy skin test? ____ Yes ____ No

SURGERIES AND HOSPITALIZATIONS:

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ____ Yes ____ No

If yes, please list type of problems: _____

List any surgeries you have had (including dates):

Have you ever been hospitalized for non-surgical reasons? ____ Yes ____ No

If yes, list reasons for hospitalizations _____

CURRENT OR MOST RECENT OCCUPATION: _____

*Please proceed to the next page.