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: _____ Height: _____ Weight: _____

For Nurse:
B/P _____ Pulse: _____

Primary Care Physician: _____ City/State: _____

Referring Physician: _____ City/State: _____

Pharmacy Preference: _____ City/State: _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage – Quantity and Time	How Often & When Do You Take

DO YOU HAVE A LATEX ALLERGY? ____ Yes ____ No

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

Name of Medication Allergies	Type of Reaction

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 been hospitalized for non-surgical reasons? **___Yes ___ No** *(If yes, list reasons for hospitalizations below)*

_____

_____

CURRENT OR MOST RECENT OCCUPATION: _____

TODAY'S DATE: _____