

# 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.