

## 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

### 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:** \_\_\_\_\_