PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form a 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 INFORMATION

Date: _____

Last Name _____ First Name _____ MI _____

SSN _____ - _____ - _____ Date of Birth _____ / _____ / _____ Age _____ Gender: Male ___ Female ___

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone _____ - _____ - _____ Cell _____ - _____ - _____ Other _____ - _____ - _____

Name of Primary Care Physician: _____

Pharmacy Preference (include location): _____

REASON FOR TODAY'S VISIT:_____

PLEASE LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLEGERIC 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 the types of problems:_____

_____

The following family members/friends can call to get information regarding my medical record, appointments, or billing issues:

1. _____
2. _____
3. _____

☐ Do not speak to anyone regarding my medical record, appointments, and billing issues.

I have reviewed the above information and verify that it is accurate.

Patient Signature _____ Date _____/ _____ / _____