Patient Health History

In order for us to obtain a complete medical history, it is important to fill out this form as complete as possible. Please make sure you review all areas in this form. All the information will be entered into our computer along with all your medical records.

Patient's Last Name________________________ First_____________________ MI__________

Sex: Male___ Female___ Date of Birth ______/_________/_________

If a minor please write Guardian/Parents full names:___________________________________

Name of Pharmacy:____
(Please include cross roads)
Name of Primary Care Physician:____

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:

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 type of problem:__________________________________
____

Have you ever been hospitalized for non-surgical reasons? Yes___No___
If yes, list reasons for hospitalizations:____
____

Current of most recent occupation:____

How did you hear about us?:____