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.

Last Name: _____ First: _____ MI: _____

Sex (please circle): Male Female

Current or most recent occupation: _____

Name of Primary Care Physician: _____

Pharmacy Preference (include location): _____

Reason for Today's Visit: _____

Please list all medications you are currently taking:

Medication	Dosage	How often Taken

Are you allergic to any medications: 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 numb or put to sleep)? Yes No

Please list any surgeries you've had: _____

_____

_____

Have you ever been hospitalized for non-surgical reasons? Yes No (if yes please list)_____