Dr: **Appt Date:** **PATIENT HEALTH HISTORY** **Appt Time:**

PLEASE FILL OUT EVERY ITEM. **If not applicable…Mark as N/A**. 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.

NAME: **DOB:** **ACCT#**
Primary Ins: **Secondary Ins:** **Tertiary Ins:**

Sex: ☐ Male ☐ Female **Height:** ___________ **Weight:** ___________ **BP:**___________ **Temp:**______________________________

Name of Primary Care Physician/City: _______________________ **Pharmacy/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 MEDICATIONS? ☐ **No** ☐ **Yes**…if yes, please list below:

Name of Medication	Type of Reaction

PLEASE INDICATE THE APPROXIMATE DATE OF YOUR MOST RECENT:

FLU VACCINATION	
PNEUMONIA VACCINATION	
MAMMOGRAM	
PAP EXAM	

SURGERIES & HOSPITALIZATIONS:

Have you ever had any problems with any type of anesthesia (being numbed or put to sleep)? ☐ **No** ☐ **Yes**
If YES…please list type of problems: ____
____
List any surgeries you have had (including dates or age): ____
____
____
Are there other health issues not addressed on our Medical History Forms? ___________________________
____
Have you ever been hospitalized for non-surgical reasons? ☐ **No** ☐ **Yes**
If yes, list reasons for hospitalizations: ____
____
Are you or is there a possibility that you are pregnant? ☐ **No** ☐ **Yes** ☐ **N/A**
Are you a nursing mother? ☐ **No** ☐ **Yes** ☐ **N/A**