

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 that 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.*

FULL NAME: _____ DATE OF BIRTH: _____

MALE FEMALE HEIGHT: _____ FT. _____ IN. WEIGHT: _____ LBS.

PHARMACY PREFERENCE (include location): _____

CURRENT MEDICATIONS

ARE YOU TAKING **ANY** KIND OF MEDICATION NOW? (include prescription, over-the-counter and herbal medications) NO YES

IF YES, PLEASE LIST BELOW. **INCLUDE DOSAGES.**

NAME OF MEDICATION	DOSAGE	HOW OFTEN TAKEN

KNOWN ALLERGIES

ARE YOU ALLERGIC TO **ANY** MEDICATIONS, SOAPS, LAUNDRY DETERGENTS, FOODS, ETC.? NO YES

IF YES, PLEASE LIST BELOW.

NAME OF MEDICATION, FOOD OR PRODUCT	TYPE OF REACTION

HAVE YOU HAD PROBLEMS WITH ANESTHESIA (BEING NUMBERED OR PUT TO SLEEP)? HIGH FEVER TROUBLE WITH INTUBATION (placement of breathing tube)

HAVE YOU HAD SURGERY? NO YES

IF YES, LIST TYPES AND WHEN THEY WERE DONE: _____

PREVIOUS OR OTHER MEDICAL PROBLEMS: _____

SOCIAL HISTORY

WHAT IS OR WAS YOUR OCCUPATION? _____

WHAT IS THE MAIN REASON YOU ARE SEEING THE DOCTOR TODAY? _____