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 NUMBED 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? _____

_____

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