

PATIENT HEALTH INFORMATION

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.

Patient's Last Name _____ First _____ MI _____
Sex: Male Female Race: _____ Ethnicity: _____ Date of Birth _____
Preferred Language _____ Primary Care Physician _____
Pharmacy Preference: _____
Reason for Today's Visit _____

CURRENT MEDICATIONS:

Name of Medication	Dosage	How Often Taken

Are you allergic to any medication? 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 numbed or put to sleep)? Yes No

If yes, please list the problems: _____

List any surgeries you have had (including dates):

Have you ever been hospitalized for non-surgical reasons? Yes No

If yes, list reasons for hospitalizations: _____

