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 Todays 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: