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 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 **Date of Birth: _____ Height _____ Weight _____**

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ Decline to State
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Some Other Race

Ethnicity: ☐ Decline To State ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Pharmacy Preference: _____ Preferred Language: _____
(include 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 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 type of problems: _____
_____
_____

List any surgeries you have had (including dates): _____
_____
_____

Have you ever been hospitalized for non-surgical reasons? ___Yes ___ No
If yes, please list reasons for hospitalizations: _____
_____

CURRENT OR MOST RECENT OCCUPATION: _____