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.**

Full Name ____ Male ☐ Female☐ Date of Birth ________________

Height: ________ Weight: ___________ Last Menstrual Period: ______________ Are you currently pregnant? ______

What is or was your occupation? ____

What is the main reason you are seeing the Doctor today?

CURRENT MEDICATIONS

Are you taking ANY kind of medication now? ☐ **No** ☐ **Yes**

Please list **ALL** prescription, over-the-counter, herbal pills, and vitamins below and include dosages.

Name of Medication	Dosage	How often taken

MEDICATION ALLERGIES

Are you allergic to any medications? ☐ **No** ☐ **Yes** If yes, please list below.

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS

Have you had surgery? ☐ **No** ☐ **Yes** If yes, please list below.

Name of Surgery	Date

Have you had problems with anesthesia (being numbed or put to sleep)?

☐ High Fever ☐ Trouble with Intubation (Placement of Breathing Tube) ☐ Nausea or Vomiting ☐ Other

Signature and Date ____________________________________

OFFICE USE ONLY (UPDATE)