PATIENT HEALTH HISTORY

Full Name _____ Male ☐ Female☐ Date of Birth _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Height: _____ Weight: _____ Last Menstrual Period: _____ Are you currently pregnant? _____

If over 50, last Colo-rectal screening: _____ If over 65, last Pneumonia Vaccine: _____

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

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

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

Name of Surgery	Date

Signature and Date _____

OFFICE USE ONLY (UPDATE)