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 that 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.

Social Security Number (SSN) ______________________________ Appointment Date ______________

Full Name ______________________________ Male Female Date of Birth ______________

Pharmacy Preference (include location) ______________________________

Name of Primary Care (Family) Physician (or Referring Physician) ______________________________

Address ______________________________ Phone ______________

Current Medications

Please list any medications (prescription, over-the-counter, herbal, etc.) and dosages.

Medication Name	Dosage	How Often Taken

Medication Allergies

Please list any medications (prescription, over-the-counter, herbal, etc.) you are allergic to.

Medication Name	Reaction Type (Swelling, Rash, etc.)

Surgeries or Procedures

Please list any previous surgeries or procedures.

Surgery / Procedure	Date

I certify the information provided is complete and accurate. Any discrepancies or changes will be reported immediately.

______________________________ ______________________________ ______________

Patient Name Patient Signature Date