

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. **Please fill out every item.**

Date:_____ Patient's Name: (Last)_____ (First)_____ (MI)_____

Male:____ Female:____ Date of Birth:_____ Height:_____

REASON FOR YOUR VISIT:_____

PHARMACY (include location):_____

MEDICATIONS: List all meds you are currently taking or provide list. Write on back of paper if needed.

NAME OF MEDICATION:	DOSAGE:	HOW OFTEN TAKEN:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ARE YOU **ALLERGIC** TO ANY MEDICATIONS? YES_____ NO_____ (If yes, please list below):

NAME OF MEDICATION:	TYPE OF REACTION:
_____	_____
_____	_____
_____	_____

PARENTS HEALTH STATUS: Mother: Living ____ Deceased ____ Father: Living ____ Deceased ____

List any hospitalizations:_____

List any surgeries including dates:_____

History of chemotherapy: ____ Radiation: ____ Why? _____ When? _____

List medical diagnosis (autism, diabetes, hypertension, etc.):_____

List most recent date of the following vaccines: Flu shot: _____ Pneumonia: _____ COVID: _____

Current tobacco use: Never: ____ Current: ____ Former: ____ Social: ____ Type: _____

How many per day: Cigarettes: _____ Vapes: _____ Smokeless Tobacco: _____

Current alcohol use: Never: ____ Rarely: ____ Frequently: ____ Daily: ____ Amount: _____

Current caffeine use: Never: ____ Rarely: ____ Frequently: ____ Daily: ____ Amount: _____