PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form in its entirety. 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:**

Name of Primary Care Physician:

Pharmacy Preference (include location):

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: ☐ **No Medications**

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

Medical History (check all that apply):

- ☐ **Asthma**
- ☐ **High Cholesterol**
- ☐ **Hypothyroidism**
- ☐ **Hypertension**
- ☐ **Diabetes**
- ☐ **COPD**
- ☐ **Depression**
- ☐ **Sleep Apnea**
- ☐ **Cancer, type: _____**
- ☐ **Peripheral Neuropathy**
- ☐ **Fibromyalgia**
- ☐ **Pacemaker**
- ☐ **Heart Disease**
- ☐ **AFib**
- ☐ **Drug Addiction**
- ☐ **Hepatitis, type: _____**
- ☐ **Osteoarthritis**
- ☐ **Osteoporosis**
- ☐ **Rheumatoid Arthritis**
- ☐ **Gout**
- ☐ **GI Bleed**
- ☐ **Acid Reflux**
- ☐ **Recurrent UTIs**
- ☐ **Blood Clots/DVT**
- ☐ **Stroke**
- ☐ **MRSA/Staph Infection**
- ☐ **Alcohol Abuse**
- ☐ **HIV**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**

SURGERIES AND HOSPITALIZATIONS:

Have you ever had any problems with anesthesia (being numbed or put to sleep)? Yes ☐ No ☐

If YES, please list the type of problems:

List any surgeries you have had (including dates):

Have you ever been hospitalized for non-surgical reasons? Yes ☐ No ☐

If YES, list reasons for hospitalizations:

CURRENT OR MOST RECENT OCCUPATION: