Patient Health History

Patient Instructions: It's critical that your doctor understand your complete health history. Please complete **each section** below as accurately as possible. This information needs to be updated every six months. Let us know if you would like a copy of your history.

Today's Date:

Physician's Name:

Patient Information

First Name: MI: Last:

Preferred Name: Gender: DOB: Age:

Current Weight: Height:

Provider Information

Primary Care Doctor: Phone: FAX:

Are you coming to us because of a physician referral? ☐ Yes* ☐ No

*Referring Physician: Phone: FAX:

Preferred Pharmacy: Phone: FAX:

Pharmacy Location:

Describe the Reason for Today's Visit

List All Medications you are Currently Taking

Name of Medication	Dosage	Frequency

List All Allergies

Are you allergic to Latex? ☐ Yes ☐ No If "Yes," list reaction:

Allergy	Type of Reaction

Please complete the reverse side of this form.

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List All Surgeries and Hospitalizations

Surgeries / Hospitalizations (including non-surgical hospitalizations)	Date

Signature of Patient or Guardian*: ________ Date: ________

Print Name: ________

☐ Patient is a minor

*If signed by Guardian, please indicate relationship to the Patient: ________

For Office Use Only – Do Not Write Below This Line

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