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.**

Date:_____ Physician you are seeing here today: _____Insurance:_____

Patient's Name Last: _____ First: _____ MI:_____

____ Male ____Female Date of Birth: _____ Height: _____

PHARMACY PREFERENCE (include location):_____

REASON FOR YOUR VISIT:

MEDICATIONS: Please list any medications you are currently taking (if not bring your bottles/printout)

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: Living: (Mother_____ Father_____) Deceased: (Mother _____ Father _____)

LIST ANY SURGERIES you have had (including dates): _____

_____

_____

List year of Mammogram _____ Pap Smear _____ Colonoscopy _____

Are you up-to-date on the Flu Shot? (Y) (N); if yes, date _____
If you are over 65, have you had the Pneumonia vaccine? (Y) (N); if yes, date _____

Current Tobacco User ? (Y) (N) How many packs per day? _____ Interested in Quitting? (Y) (N)

Use of Alcohol: Never _____ Rarely _____ Frequently _____ Amount _____