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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.

CURRENT MEDICATIONS: Are you taking ANY kind of medication now? Yes No
(This includes prescription, over-the-counter or herbal medications). Please list below.

Medication Name	Dosage	Frequency (how many times a day)

MEDICATION ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS? Yes No *If yes, please list below.*

Medication Name	

HAVE YOU HAD ANY SURGERIES OR PROCEDURES? Yes No *If yes, please list below.*

Patient/Legal Guardian Signature: Date: _____

Nurse Signature: Date: _____