PATIENT HEALTH HISTORY

NEW PATIENTS: Please fill this form out as completely as possible.
RETURNING PATIENTS: Please update with any changes since your last visit.

Name: ____ Date of Birth: __________________

Race/Ethnicity (check all that apply):

☐American Indian/Alaskan Native
☐Asian
☐Black/African American
☐Native Hawaiian
☐Other Pacific Islander
☐White
☐Hispanic or Latino
☐Other
☐Decline to state

Male: _____ Female: _____ Preferred Language: _____________________
Referring Provider: _________________________ Primary Physician: _______________________________
Pharmacy Preference (include location): ____
REASON FOR TODAY'S VISIT: ____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

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

PAST MEDICAL HISTORY (Please list any medical conditions not stated on bubble sheet)
____
____
Have you ever had any problems with anesthesia (being numbed or put to sleep)? Yes No
If yes, please list type of problems: ____
LIST ANY SURGERIES INCLUDING DATES: ____
____
____
Have you ever been hospitalized for non-surgical reasons? Yes No
If yes, please list type of problems: ____

HAVE YOU HAD ANY OF THE FOLLOWING TESTS OR IMMUNIZATIONS? (Please circle yes or no)

Recommended vaccinations up to date?	Yes No	
Influenza vaccine	Yes No Declined	Date:
Pneumococcal vaccine	Yes No	Date:
Tobacco user	Yes- current Yes- previously Never	Type: How many years/Quit Date?
Mammogram: Have you had breast cancer?	Yes No Yes No	Date:

CURRENT OR MOST RECENT OCCUPATION: ____