

PATIENT HEALTH HISTORY

PLEASE FILL OUT EVERY ITEM.

Patient's Name (First, Last, MI) _____

Family Physician _____ Referring Physician _____

Pharmacy Preference (include location) _____

REASON FOR TODAY'S VISIT _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (Including over-the-counter medication)

ARE YOU CURRENTLY TAKING ALLERGY INJECTIONS? YES NO

ARE YOU NOW USING A CPAP MACHINE? YES NO

ARE YOU ALLERGIC TO ANY MEDICATION? YES NO If yes, please list below:

Name of Medication	Type of Reaction (Ex. Rash, Nausea, Vomiting, Other)

SURGERIES AND HOSPITALIZATIONS

Have you ever had problems with anesthesia (being numbed or put to sleep)? YES NO

If yes, please list types of problems _____

List any surgeries you have had _____

Have you been hospitalized in the last 3 months? YES NO

If yes, list reason: _____

CURRENT OR MOST RECENT OCCUPATION _____