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 welcomed to a copy of the report if you wish.

Full Name_____ **Male**_____ **Female**_____ **Date of Birth**_____

Pharmacy (including location)_____ **Primary Care Physician**_____

Have you seen us (please check all that apply) Billboard_____ **Newspaper**_____ **Radio**_____ **TV**_____ **Web**_____ **Other**_____

Who can we thank for referring you? Self_____ **Family/Friend**_____ **Physician**_____ **Name**_____

State in your own words why you are here today._____

Patient's Zip Code_____

(Current Medications) Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications) YES_____ **NO**_____ **If yes, please list below *INCLUDING DOSAGE.***

MEDICATION NAME	DOSAGE/MG	HOW OFTEN TAKEN

(Medication Allergies) ARE YOU ALLERGIC TO ANY MEDICATIONS? YES_____ **NO**_____ **If yes, please list below.**

MEDICATION NAME	TYPE OF REACTION (Rash, Swelling, etc.)

Have you had any problems with anesthesia? YES_____ **NO**_____

Have you had any Surgery or Procedures? YES_____ **NO**_____ **If yes, please list below.**

TYPE OF SURGERY OR PROCEDURE	DATE OF SURGERY OR PROCEDURE