## 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 (include 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	ly/Friend Physician Name	
State in your own words why you are here today.		
(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 include dosages.		
Medication Name	Dosage How often Taken	
-		
(Medication Allergies) ARE YOU ALLERGIC TO ANY	·	
If yes, please list below.  Medication Name	Type of Reaction (Rash, Swelling, etc.)	
PARTICULAR ATTEMAT	A pot of Medicion (Among Stroning) 555%	
,		
Have you had any problems with anesthesia? YesNo Have you had any Surgery or Procedures? YesNoIf yes, please list below.		
Type of Surgery or Procedure	Date of Surgery or Procedure	•
•		