PATIENT HEALTH HISTORY

Patient Last Name:	First Name:

Sex ☐ Male ☐ Female

Date of Birth:

Name of Primary Care Physician:

Name of Referring Physician:

What Pharmacy Do You Use and Where?

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage & How often	Reason for taking medication

ALLERGIES TO MEDICATIONS

Name of Medication	Type of Reaction

PAST MEDICAL HISTORY

Illnesses/Hospital Stays, Injuries & Surgeries	Date	Hospital	Treatment

Have you ever had any problems with anesthesia(being numbed or put to sleep)? Yes/No

If Yes, Please list type of problems:____________________________

CURRENT OR MOST RECENT OCCUPATION: