PATIENT HEALTH HISTORY

Patients Name_______________________________________ **DOB**____________________ **DATE:** ____________________

RACE: (circle one) Unspecified, Decline to state, American Indian or Alaskan Native, Native Hawaiian, Black or African American, White, Or Other

REASON FOR VISIT:____

ETHNICITY: (circle one) Decline to state, Hispanic or Latino, Non-Hispanic or Latino

PREFERRED LANGUAGE: (circle one) English or Spanish **Height** ________ ft. ________ in. **Weight** ______________ lbs.

CURRENT OR PAST OCCUPATION: ____
PHARMACY PREFERENCE: (include location) ____

PLEASE LIST ALL MEDICATIONS: PRESCRIBED AND OVER THE COUNTER!!!!

NAME MEDICATION	DOSAGE	HOW OFTEN TAKEN	REASON

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **YES** ☐ **NO** IF YES PLEASE LIST

NAME OF MEDICATION	TYPE OF REACTION

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Please check and DATE all that apply)

☐ High Blood Pressure_________________

☐ Abnormal Heart Rhythm__________________

☐ Heart Failure___________________

☐ Seizures_______________

☐ Stroke_________________

☐ Kidney Disease___________________

☐ Diabetes_______________

☐ Bleeding Problems_________________

☐ Blood Clots_____________

☐ Cancer________________

☐ Mammogram___________

☐ Pneumonia_____________

☐ Flu Shot_______________

☐ Colonoscopy____________

Email for Patient Portal (☐ Decline Patient Portal**)**____

COMPLICATIONS WITH ANESTHESIA (BEING NUMBED OR PUT TO SLEEP**)** ☐ **Yes** ☐ **No** _____________________________________

LIST ANY OTHER MEDICAL CONDITIONS NOT ALREADY LISTED:____

____

PAST SURGERIES: (Please list Procedure and date when done)____

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