

HEALTH HISTORY



Date ___/___/___

File #: _____

NAME

Last First Middle

SEX: Male Female

DATE OF BIRTH ___/___/___

What is the reason for your visit?

What do you think caused this problem?

PERSONAL HEALTH HISTORY

Please list any medical conditions or symptoms you are currently experiencing, or have experienced during the past year:

Please tell us about any hospitalizations, serious illnesses or surgeries:

Year	Reason	Hospital	Outcome

List your prescribed medications, over-the-counter medications, herbs, vitamins and inhalers:

Name	Dosage	Frequency Used

Please provide details of any known allergies (e.g., latex, medications, foods)

Allergen	Reaction

Neurological (brain, nerves)					
Gastrointestinal (stomach, intestines)					
Muscle / Joint / Bone					
Genitourinary (urinary, kidney, prostate)					
Psychological					
Respiratory (lung, breathing)					
Skin					

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Patient Signature

Date