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.

FULL NAME: DOB Pharmacy:

CURRENT MEDICATIONS: Are you taking ANY kind of medication? (This includes prescription, over-the-counter or herbal medications) YES____ NO_____ If yes, please list below

Medication Name	Dosage	How Often Taken

MEDICATION ALLERGIES/ALLERGIES: Are you allergic to any medications? YES____ NO_____ If yes, please list below

Name of Medication	Type of Reaction (Rash, Swelling, etc.)

Have you had any surgery or medical procedures? YES____ NO_____ If yes, please list below

Type of Surgery or Procedure	Date of Surgery or Procedure

Have you had any serious injuries or accidents that we need to know about?_____

_____

Colonoscopy:_____ Flu Shot:_____

Pneumonia Vaccine:_____ Pap Smear:_____

Mammogram:_____