



PATIENT HEALTH HISTORY FORM

Name: _____ Date of Visit: _____

Date of Birth: _____ Age: _____ Sex: (F) (M)

Please answer all the following questions, trying not to leave any blank.

Due to insurance industry's need to fully understand your medical needs it is necessary to complete as much of this form as necessary. This will also assist our office in assessing your particular needs for proper medical care.

Past Medical History

1) Have you ever been in the hospital as a patient? Yes No
 if yes, specify when and for what reason: _____

2) Have you ever had surgery of any kind? Yes No
 if yes, specify when and what type of surgery: _____

CURRENT MEDICAL HISTORY

3) Do you have?

	Yes	No	Medications		Yes	No	Medications
Heart Disease				Pacemaker			
Lung Disease				Anemia			
Hepatitis				Arthritis			
Leg Ulcer				Diabetes			
Asthma				Thyroid			
High Blood Pressure							

4) Are you presently under the care of a physician? Yes No If yes, please indicate who an for what illness or purpose: _____

5) Please list all current medications (prescription & non-prescription)

Medication	Dosage	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____



- 2) How many times have you been pregnant? Yes No
- 3) Do you intend to have any more children? Yes No
- 4) Are you currently breast-feeding? Yes No