

PATIENT HEALTH HISTORY FORM



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Patient Name: _____ Today's Date: _____ Date of Birth: _____

Reason for today's visit (be as brief as possible): _____

Is current problem is the result of? (check all that apply) Work accident Motor vehicle accident Accident Other

I. PAST MEDICAL HISTORY

1. Please list prior illnesses and/or injuries (give dates if known):

Description Of Illness or Injury	Approximate Date(s)

2. Please list any known allergies, including foods:

3. Please list all surgeries and/or hospitalizations (give dates, if known):

Description Of Surgery Or Hospitalization	Approximate Date(s)

4. Have you ever had problems with anesthesia? (if yes, please explain): No Yes _____

5. Please list all current medications. Provide drug name, dosage and frequency.

M E D I C A T I O N	D O S A G E	F R E Q U E N C Y

6. _____
Patient Signature Today's Date Physician Signature Today's Date