# PATIENT HEALTH HISTORY

**Patient's Last Name _____First _____ MI _____**

Height _____ Weight _____

**Primary Care Physician: _____ Referring Physician: _____**

**Pharmacy Preference (include location):_____**

**REASON FOR TODAY'S VISIT: _____**

**PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: (i.e. NSAIDs/arthritis, steroids, pain meds, anti-depressants, antibiotics, blood thinners)**

| Name/Dosage | Taken for | Name/Dosage | Taken for |
|---|---|---|---|
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**ARE YOU ALLERGIC TO ANY MEDICATION? ____ Yes ____ No.** If yes, please list below:

| Name of Medication | Type of Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Are you allergic to Contrast Dye?**
____Yes ____No
If yes, please list type of problems:
_____
_____

**SURGERIES AND HOSPITALIZATIONS**

List any surgeries you have had (including dates):
_____
_____
_____
_____
_____

_____ _____
Patient Signature Date