PATIENT HEALTH HISTORY

Please fill out every item. This information is important for your provider to have to care for your medical needs. Once complete, it will be entered into your Electronic Medical Record (EMR). You are welcome to a copy of the report if you wish. Thank you for your cooperation. APENT FAMILY.

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

Sex Male Female **Date of Birth:** _____

Name of Primary Care Physician: _____

Pharmacy Preference (include location): _____

REASON FOR TODAY'S VISIT: _____

Height: _____ **Weight:** _____ **(Please specify ft./in/cm, lbs./kg)**

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: (Mark N/A where appropriate)

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? ____ Yes ____ No. If yes, please list below:

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS.

Have you ever had any problems with anesthesia or numbing medications? ____Yes ____No

If yes, please list medication with reaction: _____

_____

_____

List any surgeries you have had (including dates):

_____

_____

_____

Have you ever been hospitalized for non-surgical reasons? ___Yes ___ No

If yes, list reasons for hospitalizations: _____

CURRENT OR MOST RECENT OCCUPATION: _____