

Health History

Name _____ Account# _____ DOB: _____

Primary Care Physician: _____

Medical History: list medical problems that you have been treated for in the past and current problems you are being treated for.

Empty table for medical history with 6 rows.

Surgical History: List all previous surgeries

Empty table for surgical history with 3 rows.

List allergies to medications:

Empty table for allergies to medications with 2 rows.

Current Medication: List all medication you are taking. Include dosages and frequency.

Table with 3 columns: Medication, Dosage, Frequency. Contains 6 empty rows.

Family Medical History:

Empty table for family medical history with 2 rows.

Review of Systems: Circle all that apply

- Headache, Dizziness, Recent change in vision, Visual disturbances, Decreased smell, Hoarseness, Abdominal pain, difficulty swallowing, heat or cold intolerance, unexplained weight loss, chest pain, shortness of breath, Wheezing, diarrhea, difficulty breathing, palpitations, exercise intolerance, heartburn, vomiting, constipation, frequent urination, anxiety, cough, nausea, Hearing loss, tremors, chills, depression

Dominant Hand: _____ Right _____ Left

Tobacco Use: _____ No _____ Yes, pack per day _____ for _____ years

Alcohol Use: _____ No _____ Yes, how often _____ How much _____

Occupation _____

Height _____ Weight _____

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