PATIENT HEALTH HISTORY **ID#_____**

Patient's Last Name _____First _____ MI _____
Address_____City_____ST_____
Zip_____PHONE_____

EMAIL _____ Height _____ Weight _____

Primary Care Physician: _____ Referring Physician: _____

Last FLU Vaccine:_____ Last Pneumonia Vaccine:_____

Diagnosed with MRSA: YES or NO _____DATE:_____

Screening for Colorectal Cancer:_____
Date of Last Colonoscopy (Ages 50-75):_____

Female Patients:
Date of Last Pap Smear (Ages 21-64 _____
Date of Last Mammogram (Ages 50-74)_____

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

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