PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Social Security Number (SSN) ______________________________ Appointment Date _________________

Full Name ________________________________Male ____ Female____ Date of Birth __________________

Pharmacy Preference (include location) ____

Name of Primary Care (Family) Physician _________________________ Address ______________________

How Did You Hear About Us? ____

(Current Medications) Are you taking ANY kind of medication now? Yes____ No _____
This includes prescription, over-the-counter or herbal medications)

Medication Name	Dosage	How often Taken

(Medication Allergies) ARE YOU ALLERGIC TO ANY MEDICATIONS? Yes ___ No ___
If yes, please list below.

Name of Medication	Type of Reaction (Rash, Swelling, etc.)

HAVE YOU HAD ANY SURGERY OR PROCEDURE? Yes______ No ______
If yes, please list below.

Type of Surgery or Procedure	Date of Surgery or Procedure (if known)

What is the Main reason you are here to see the Physician Today?

Please Circle the Type of Pain you are having:

Burning, Stabbing, Aching, Sharp,

How long have you been having Pain in this location?

___Hours ___ Days ___Months ___Years

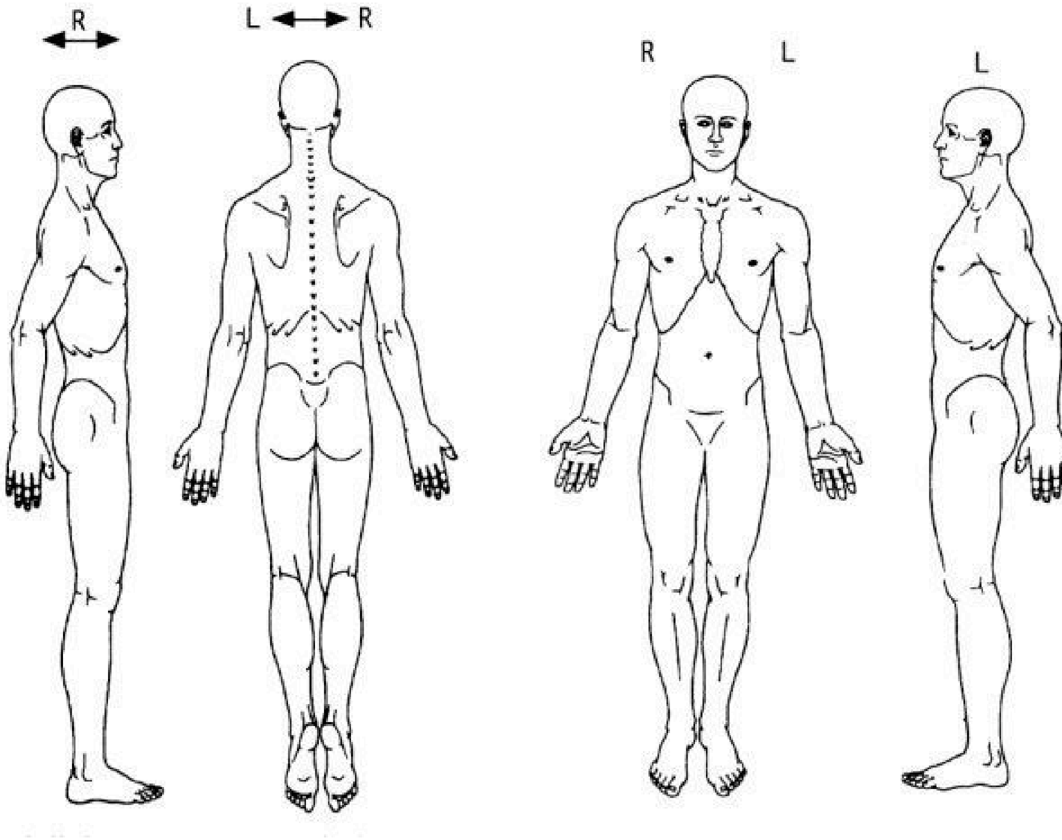
Is this a Worker's Comp related problem? Yes___ No___

If Yes, When did the injury occur? Date _____________

On a scale of 1-10 with 10 being the worst pain you ever experienced, what would you rate your Pain today?

Please circle 1 2 3 4 5 6 7 8 9 10

Please mark the body below in the location you are having pain:



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Patient Signature / Date