HEALTH HISTORY

Personal Information Date:_____

Patient Name: _____ Birth Date: _____/_____/_____ Age: ____

Occupation _____ Marital Status: _____ Name of Partner/Spouse: _____

Race: ☐ Asian ☐ Black or African American ☐ Native American ☐ White / Caucasian

☐ Other: _____

Ethnicity: Do you identify with an Ethnic origin? If yes, please note: _____

Number of children: _____ Children's Names/Ages: _____

Names/Specialties/Locations of Other Physicians Caring for You, including previous primary care doctor:_____

_____

_____

Medical Information

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Medication	Dosage	Route	Frequency

Any **Allergies** to Medication or Food (list reactions): _____

Preferred **Pharmacy**: _____

Date of Last Complete Physical Exam: _____ Date of Last Blood Work: _____

Date of Last Colonoscopy: _____ Date of Last Tetanus Shot: _____

For Females: Date of Last Menstrual Period: _____ Date of Last Pap Smear: _____

History of Abnormal Pap (list date/s)? _____ Date of Last: Mammogram: _____ DEXA: _____

Number of Pregnancies: _____ Miscarriages: _____ Terminations: _____ Living Children: _____

Method/s of Contraception: _____