Patient History Form

Date _____

First Name _____ Last Name _____Date of Birth _____Age _____

Address_____ City_____State_____Zip Code_____

Phone Number _____ Cell_____

Email_____

Would you like access to the Patient Portal? _____YES _____NO

Social Security Number _____ /_____/_____ Weight _____Height_____Sex: M F

What brings you to see us (be brief)? _____

Do you have any medical problems?_____

_____

Have you had any surgeries before? When? _____

_____

Any medical problems run in the family? _____

_____

Last Tetanus Shot Date? _____ Are all other shots up to Date?_____

Please list your **current medications** (*including over the counter and herbal supplements*) you may provide a list to the nurse:

Name	Dose	Name	Dose
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Are you allergic to any medications? Please list and describe the kind of reaction do you get_____

_____

Do you smoke, or ever smoke?_____ How much per day?_____ For how long? _____ If quit, when?_____

Do you drink alcohol?_____ How many drinks per week? _____ Do you use any recreational drugs? _____

Have you done any recent traveling in the past 30 days? Yes No

If so where? _____

Are you (Circle One) Employed, (occupation) _____ **Student Not Working Retired**

If yes Employer Name_____Employer Address_____

Employer Phone Number_____

Insurance Subscriber's Information: ☐ **Same as Patient**

Name of person:_____

Address:_____

_____

Date of Birth: _____

Social Security: _____

Phone Number:_____

Relationship to patient: _____

Can we release your records to your primary care physician? Yes No

Primary Care Physician _____Primary Care Phone Number_____

Pharmacy Name_____Pharmacy Number_____

Emergency Contact _____Relationship_____Phone Number_____