

HEALTH HISTORY FORM-ESTABLISHED PATIENTS

Patient Name: _____ **Birthdate:** _____ **Date:** _____
PCP Physician: _____ **Pharmacy:** _____ **Phone:** _____

Reason for today's visit: _____

Please describe this problem: _____

Any new procedures/surgeries done since you last saw us? No Yes Explain _____

Please list any medication changes since you were last seen? No changes List: _____

Any new allergies? No Yes Explain: _____

Do you smoke? No, and never have Yes Explain _____

Any changes to your family history? No Yes Explain: _____

Any changes in your symptoms? No Yes Explain below:

<input type="checkbox"/> General _____	<input type="checkbox"/> Heart _____
<input type="checkbox"/> Eyes _____	<input type="checkbox"/> Lungs _____
<input type="checkbox"/> Ears, Nose, Mouth/Throat _____	<input type="checkbox"/> Stomach _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Urinary _____
<input type="checkbox"/> Neurological _____	<input type="checkbox"/> Endocrine _____
<input type="checkbox"/> Psychiatric _____	<input type="checkbox"/> Blood _____
<input type="checkbox"/> Musculoskeletal _____	<input type="checkbox"/> Other _____

All systems other than what is marked above have also been reviewed and are negative.

Anything else that you would like to talk with the doctor today?

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes in my health.

Other Signature: _____ **Designation:** _____ **Date:** _____

Physician Signature: _____ **Date reviewed:** _____