Health History
(Confidential)

Name_____ Date:_____

Age_____ Birthdate_____ Date of last physical_____

Reason for your visit_____

Date of last menstrual period:_____ Date of last pap smear:_____

Are you pregnant? Y N Number of children:_____

IMMUNIZATIONS

Influenza (Flu)	Y N	Month/Year_____
Pneumonia	Y N	Month/Year_____
Shingles	Y N	Month/Year_____
Tetanus shot	Y N	Month/Year_____

HEALTH MAINTENANCE

Colonoscopy (Month/Year)_____ Diabetic Eye Exam (Month/Year)_____

Mammogram (Month/Year)_____ ___ Bone Density (Month/Year)_____

PSA -Males (Month/Year)_____

Have you ever had a blood transfusion? Y N If yes, give approximate dates:_____

MEDICATIONS (List all medications you are taking)

_____

_____

_____

_____

Medication Allergies:_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date