HEALTH HISTORY UPDATE

Patient Name: _____ D.O.B: _____

Home Address: _____ Height: _____

Home/Cell Phone #: _____ Weight: _____

Email Address: _____ Current Smoker: ___Yes ___No

Primary Care Physician: _____

Has there been any changes in your health since your last visit? If Yes, please explain. ❑ No Changes

_____

_____

Has there been any changes in your medications since your last visit? If yes, please list. ❑ No Changes

_____

_____

Do you have any new allergies to medications since your last visit? If yes, please list medication and reaction. ❑ No Changes

_____

Are there any new illnesses, hospitalizations, surgeries, or problems since your last visit? If yes, please explain: ❑ No Changes

_____

_____

_____

_____ _____

Patient/ Parent/Legal Guardian Signature Date