

HEALTH HISTORY FORM

Today's Date: _____		Primary Care Provider / Address: _____	
PATIENT INFORMATION			
Last Name: _____		First Name: _____ Middle Initial: _____	
Address: _____		Date of Birth: ____/____/____ Phone #: _____	
Primary Language: ☐ English ☐ Arabic ☐ French ☐ German ☐ Mandarin ☐ Spanish ☐ Russian ☐ Other			
Race: ☐ American Indian ☐ Asian ☐ African American or Black ☐ Native Hawaiian/Other Pacific ☐ White ☐ Unknown ☐ Other			
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino			
Primary Pharmacy: _____		Address: _____	
Prescription Benefits Provided By (i.e. Express Scripts, Medco, etc.): _____			

REASON FOR TODAY'S VISIT			
Concern: _____	Location: _____	Duration: _____	Prior Treatments: _____
Concern: _____	Location: _____	Duration: _____	Prior Treatments: _____

PAST MEDICAL HISTORY			
CRITICAL INFORMATION		MEDICAL HISTORY	
Adhesive tape / latex allergy	☐ Yes ☐ No	Abnormal moles	☐ Yes ☐ No
Anticoagulant treatment	☐ Yes ☐ No	Abnormal scars	☐ Yes ☐ No
Artificial heart valves	☐ Yes ☐ No	Acne	☐ Yes ☐ No
Artificial joint	☐ Yes ☐ No	Actinic keratosis	☐ Yes ☐ No
Bacitracin / Neosporin allergy	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Bleeding disorders	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Breast cancer / Other cancer	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Eczema	☐ Yes ☐ No
Epinephrine sensitivity	☐ Yes ☐ No	Hay fever	☐ Yes ☐ No
Fainting / syncope	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	HSV / cold sore	☐ Yes ☐ No
HIV positivity	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No
Hypertension	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Immunosuppressive therapy	☐ Yes ☐ No	Multiple sclerosis	☐ Yes ☐ No
Local anesthetics allergy	☐ Yes ☐ No	Parkinson's disease	☐ Yes ☐ No
Lymphoma	☐ Yes ☐ No	Poor wound healing	☐ Yes ☐ No
Memory problems	☐ Yes ☐ No	Psoriasis	☐ Yes ☐ No
Mitral valve prolapse	☐ Yes ☐ No	Rosacea	☐ Yes ☐ No
MRSA	☐ Yes ☐ No	Seasonal allergies	☐ Yes ☐ No
Organ transplant	☐ Yes ☐ No	Thyroid disease	☐ Yes ☐ No
Pacemaker / defibrillator	☐ Yes ☐ No	Warts	☐ Yes ☐ No
Pre-op/pre-dental antibiotics	☐ Yes ☐ No	Other (specify below)	☐ Yes ☐ No

Medical History Form Template

Michal Rosen-Zvi

A red circular graphic with a gradient, appearing as a partial circle or a thick arc, located to the right of the author's name.

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