PATIENT HISTORY RECORD

NT ILLNESS	REFERRED I	BY
NT ILLNESS		
	HEIGHT	WEIGHT
WHAT IS THE NATU	JRE OF YOUR PROBLEM?	?
HOW LONG HAS TH	HIS BOTHERED YOU (DAY	YS,WEEKS,MONTHS,YEARS)
HOW SEVERE IS YO	OUR PROBLEM?	MILD / MODERATE / SEVERE
EDICAL HISTORY PLEASE LIST ALL N	MEDICAL PROBLEMS (DIA	ABETES,HIGH BLOOD PRESSURE ETC.)
PLEASE LIST <u>ALL</u> F	PREVIOUS SURGERIES	
-	HOW LONG HAS TH HOW SEVERE IS YO EDICAL HISTORY PLEASE LIST ALL M	HOW LONG HAS THIS BOTHERED YOU (DAY HOW SEVERE IS YOUR PROBLEM? EDICAL HISTORY PLEASE LIST ALL MEDICAL PROBLEMS (DIA

1. DO YOU SMOKE?

YES / NO

MEDICATIONS

LIST ALL MEDICATIONS	DOSE	# PILLS	TIMES TAKEN PER DAY	DATE MEDICATION
	(mg)			STOPPED

ALLERGIES

PLEASE LIST ALL MEDICATION ALLERGIES

PREVENTATIVE PROCEDURES & MEDICATION

Procedure	Date	**Medication Allergies**
Mammogram		
Pap Smear Blood Chemistry		
Chest X-Ray		
Hemoccult		
Colonoscopy		
Tetanus		
TB Flu Shot		
HPV Vaccine (Gardasil)		