Health History

PATIENT INFORMATION (CONFIDENTIAL) Today's Date _____

Name: _____ Birth Date: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Social Security #: _____

RESPONSIBLE PARTY

Name of Person Responsible for the Account: _____

Relationship to Patient: _____ Driver's License #: _____

Birth Date: _____ Home Phone: _____ Cell Phone/Pager: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Social Security #: _____

MEDICAL HISTORY

Have you ever had any of the following medical problems?

Y N Allergies to any drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Heart Defects
Y N Asthma / Lung Problems
Y N Hepatitis / Liver problems
Y N Kidney Problems
Y N Bleeding Problems
Y N Heart Murmurs
Y N Sleep Apnea
Y N WOMEN: Is there any possibility that you could be pregnant?

Y N Diabetes
Y N Seizures / Epilepsy
Y N Handicaps / Disabilities
Y N Cerebral Palsy
Y N Developmentally Delayed
Y N Rheumatic / Scarlet Fever
Y N Cancer
Y N Hearing Impairments
Y N Tuberculosis

Please discuss any medical problems that you have/had: _____

_____

_____

Physician: _____ Phone Number: _____

Are you currently under the care of a physician: Yes No Date of Last Visit: _____

Please describe your current physical health: Excellent _____ Good _____ Poor _____

Please list all medications you are currently taking: _____

_____

Please list all allergies you have, including medications: _____

The information on this questionnaire is accurate to the best of my knowledge. I understand that the information will be held in the strictest of confidence and it is my responsibility to inform Dr. Marjon Jahromi of any changes in my medical status at the earliest possible time.

_____

Signature of Patient Date

Reviewed by: _____ Date _____