# HEALTH HISTORY ESTABLISHED PATIENT

OUR FAMILY CARING FOR YOUR FAMILY SINCE 1988


PATIENT NAME: _____

DATE OF BIRTH: _____

CELL PHONE: _____ EMAIL _____

ADDRESS: _____

PREFEERED METHOD OF CONTACT: PHONE TEXT EMAIL

ANY CHANGES IN INSURANCE? YES _____NO___
ANY CHANGES IN HEALTH? YES: _____NO___
ANY SURGERY OR HOSPITALIZATIONS, IN THE PAST YEAR? YES_____NO___
ANY CHANGES TO DENTAL HEALTH? YES_____NO___
ANY COVID SYMPTOMS/EXPOSURES: YES, WHEN _____NO___
HAVE YOU HAD THE COVID VACCINE? YES, WHEN/TYPE_____NO___
WHAT MEDICATIONS OR SUPPLEMENTS (PRESCRIPTION AND NON-PRESCRIPTION) ARE YOU ON?

_____

LIST ANY ALLERGIES TO MEDICATIONS, FOODS, OR LATEX:

_____

LIST ANY COGNITIVE IMPAIRMENTS/DEVELOPMENTAL DELAYS (AUTISM, ADHD, DEMENTIA, ETC):

_____

TOBACCO PRODUCTS USAGE? YES_____ NO_____
FEMALES: ANY CHANCE YOU MAY BE PREGNANT? YES_____ NO_____
BIRTH CONTROL PILLS: YES_____ NO_____

I CERTIFY THAT I HAVE READ AND I UNDERSTAND THE QUESTIONS ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE INQUIRIRES ABOVE HAVE BEEN ANSWERED TO MY SATISFCTION. I WILL NOT HOLD MY DOCTOR OR ANY OTHER MEMBER OF HIS/HER STAFF, RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM.

PATIENT / OR GUARDIAN SIGNATURE: _____DATE: _____