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: ____

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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: ____

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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.

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Signature of Patient Date

Reviewed by: ____ Date ______________________________