

## HEALTH HISTORY FORM

Today's Date:	Primary Care Provider / Address:		
PATIENT INFORMATION			
Last Name: _____	First Name: _____	Middle Initial: _____	Date of Birth: _____ / _____ / _____
Address: _____			Phone #: _____
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Arabic <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Mandarin <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Other			
Race: <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> African American or Black <input type="checkbox"/> Native Hawaiian/Other Pacific <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other			
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal moles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anticoagulant treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal scars	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acne	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Actinic keratosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bacitracin / Neosporin allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast cancer / Other cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epinephrine sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting / syncope	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	HSV / cold sore	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV positivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Immunosuppressive therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Local anesthetics allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lymphoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor wound healing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Memory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral valve prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rosacea	<input type="checkbox"/> Yes <input type="checkbox"/> No
MRSA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seasonal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Organ transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker / defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Warts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pre-op/pre-dental antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (specify below)	<input type="checkbox"/> Yes <input type="checkbox"/> No

# Patient Health History Update Form

**M Woodhall**



**Patient Health History Update Form:**

## Decoding **Patient Health History Update Form**: Revealing the Captivating Potential of Verbal Expression

In a period characterized by interconnectedness and an insatiable thirst for knowledge, the captivating potential of verbal expression has emerged as a formidable force. Its power to evoke sentiments, stimulate introspection, and incite profound transformations is genuinely awe-inspiring. Within the pages of "**Patient Health History Update Form**," a mesmerizing literary creation penned with a celebrated wordsmith, readers set about an enlightening odyssey, unraveling the intricate significance of language and its enduring impact on our lives. In this appraisal, we shall explore the book's central themes, evaluate its distinctive writing style, and gauge its pervasive influence on the hearts and minds of its readership.

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