Date: _____ Dr. Gupta @_____

_____ Dr. Sabour @_____

_____ Dr. Skordas @_____

Christopher Wright PA-C @ _____

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. Please fill out every item. It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Last Name _____ First Name _____

__Male __Female Date of Birth _____

Current Tel. #: (_____)_____

Pharmacy Preference _____ Location _____

Name of Primary Care (Family) Physician _____

(Current Medications) Are you taking **ANY** kind of medication now? (this includes prescription, over-the-counter or herbal medications) ____YES ____ NO If yes, please list below include dosages.

Medication Name	Doses	How Often Taken?

(Medication Allergies) Are you **ALLERGIC TO ANY MEDICATIONS** that you know of? ___YES __NO
If yes, please list below.

Name of Medication	Type of Reaction (Rash, Swelling, etc.)

Have you had any Surgery or Procedures? ___YES ____NO If yes, please list below.

Type of Surgery or Procedure	Date of Surgery or Procedure

Updated by Patient _____ _____ // _____ _____ // _____ _____

Initial Date Initial Date Initial Date