Health History Form

Established Patient
Brief Follow-up

Name: ______________________________
DOB: ______________________________
Date: ______________________________
MR#: ______________________________

Thank you for choosing our clinic for your healthcare needs! We appreciate your assistance with completing this form as it will help us better care for you. This is confidential information, and will be kept in your electronic medical record.

Please describe the reason for your visit today. Please include the date of onset and any symptoms associated with the problem.

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Have you seen or referred yourself to another physician since your last visit? What was the reason?

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Medications

Medication name	Dose and frequency	Need Refill (Y/N)?

Are you taking the above medications as prescribed (Y/N)? ______
If not, please explain.

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