**Patient Health History**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Appointment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_\_/\_\_\_\_

Reason for today’s visit (Please list ALL symptoms):

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History**

Please list any illness you had or have been diagnosed with by a physician:

**List:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preventative Health Maintenance**

1. Date of last pap smear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was your last pap smear normal? 🞐 Yes 🞐No

[If done elsewhere please bring copy of results]

1. Date of last Colonoscopy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was your last colonoscopy normal? 🞐 Yes 🞐No

3.) Date of Last Bone Density Test? \_\_\_\_\_\_\_\_\_\_\_

Was your Bone Density normal? 🞐 Yes 🞐No

1. Date of last Pelvic Ultrasound? \_\_\_\_\_\_\_\_\_\_\_\_

Was your last Pelvic Ultrasound normal?

🞐 Yes 🞐No

5.) Date of last mammogram? \_\_\_\_\_\_\_\_\_\_

Was your mammogram normal? 🞐 Yes 🞐No

**Past Surgical History OR Major Injuries: List ANY surgeries you have ever had!**

**Date and Surgery:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6.) Do you perform regular Self Breast Exams?

🞐 Yes 🞐No

7.) Date of last breast biopsy? \_\_\_\_\_\_\_\_\_\_\_\_\_

Was your last biopsy normal? 🞐 Yes 🞐No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**

**Please list all current medications prescribed by our doctors!**

**Medication Reason for Medication Dose & Frequency**

\*If using Generic medication please list the name as indicated on your prescription bottle.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List any prescriptions given by ANY other doctor:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**

🞐 NO KNOWN DRUG ALLERGIES

**Are you allergic to any medications?**

**Please list medication and reaction:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Food**

Indicate food and reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Environmental**

Indicate and reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When was your last Vaccine / Immunization:**

Flu Shot: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumonia Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shingles Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gardasil: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

What has anyone in your immediate family (mother/father/siblings/grandparents) been diagnosed with:

🞐 Illness? \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞐 who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age? \_\_\_\_\_\_\_\_\_\_ Maternal / Paternal

🞐 Illness? \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞐 who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age? \_\_\_\_\_\_\_\_\_\_ Maternal / Paternal

🞐 Illness? \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞐 who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age? \_\_\_\_\_\_\_\_\_\_ Maternal / Paternal

🞐 Illness? \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞐 who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age? \_\_\_\_\_\_\_\_\_\_ Maternal / Paternal

🞐 Illness? \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞐 who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age? \_\_\_\_\_\_\_\_\_\_ Maternal / Paternal

🞐 Illness? \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞐 who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age? \_\_\_\_\_\_\_\_\_\_ Maternal / Paternal

🞐 Illness? \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞐 who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age? \_\_\_\_\_\_\_\_\_\_ Maternal / Paternal

🞐 Illness? \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞐 who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age? \_\_\_\_\_\_\_\_\_\_ Maternal / Paternal

🞐 Illness? \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞐 who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age? \_\_\_\_\_\_\_\_\_\_ Maternal / Paternal

🞐 Illness? \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞐 who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age? \_\_\_\_\_\_\_\_\_\_ Maternal / Paternal

🞐 Illness? \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞐 who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age? \_\_\_\_\_\_\_\_\_\_ Maternal / Paternal

🞐 Illness? \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞐 who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age? \_\_\_\_\_\_\_\_\_\_ Maternal / Paternal

🞐 Illness? \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞐 who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age? \_\_\_\_\_\_\_\_\_\_ Maternal / Paternal

🞐 Illness? \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞐 who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age? \_\_\_\_\_\_\_\_\_\_ Maternal / Paternal

🞐 Illness? \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞐 who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age? \_\_\_\_\_\_\_\_\_\_ Maternal / Paternal

🞐 Illness? \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞐 what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age? \_\_\_\_\_\_\_\_\_\_ Maternal / Paternal

**Social History**

Alcohol Use 🞐Every Day 🞐Some Days 🞐Former 🞐Never Amount Used: \_\_\_\_\_ Age Start: \_\_\_\_\_ Age Stop: \_\_\_\_\_\_

Substance Drug Use 🞐Yes Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco Use 🞐Every Day 🞐Some Days 🞐Former 🞐Never Amount Used: \_\_\_\_\_ Age Start: \_\_\_\_\_ Age Stop: \_\_\_\_\_\_

Marital Status 🞐Dating 🞐Divorced 🞐Engaged 🞐Married 🞐Not dating 🞐Remarried 🞐Single 🞐Separated 🞐 Widowed

Employment 🞐 (Occupation) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞐 Unemployed 🞐 Homemaker 🞐 Student 🞐 Retired

Exercise 🞐Regular 🞐Heavy 🞐Moderate 🞐Minimal 🞐Active 🞐Competitive Athlete 🞐Sedentary

Daily Diet Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any Other Problems**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Education Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Infection Risk/Exposure:\_\_\_\_\_\_\_\_\_\_\_\_ Your Hazardous Exposure: \_\_\_\_\_\_\_\_\_\_\_

Any military history? Y / N What branch? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any domestic violence to report? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reproductive History**

**(Answer ALL questions)**

**Menstrual**

Age Period Began: \_\_\_\_\_\_

Length of periods: \_\_\_\_\_\_ # days

Number of days between periods: \_\_\_\_\_\_

Last Menstrual Period (Date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Menopause Status (pre/peri/post): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Method of Birth Control (pills, tubal, vasectomy etc.)

: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you ever have bleeding in between periods? Yes/No

Average Flow: 🞐 heavy 🞐 medium 🞐 light

Certainty of LMP Date: Y or N \_\_\_\_\_\_\_\_\_

Menopause: Y / N Age: \_\_\_\_\_

Clots(Y/N)? : \_\_\_\_\_\_\_\_\_

On Hormone Replacement Therapy (Y/N)? : \_\_\_\_\_\_

**Pregnancies**

List ALL pregnancies including terminations and miscarriages

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Total Pregnancies** | **Full Term** | **Premature** | **Ab Induced**  **(abortion)** | **Ab**  **Spontaneous (miscarriage)** | **Ectopics** | **Multiple** | **Living** |
| # | # | # | # | # | # | # | # |

**Please list all deliveries**

D.O.B. Sex of child Birth Wt # weeks at delivery Hrs in labor Type of delivery\* Anesthesia\*\* Complications\*\*\*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

\*Types of deliveries= Vaginal, c-section, forceps, vacuum OR v-bac

\*\* Types of Anesthesia= Epidural, general, spinal, IV medications OR none

\*\*\*Complications= List any problems or issues during pregnancy and at delivery

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(PatientHealthHistory\_REV\_9/2014)