Pullman Family Medicine Health History Questionnaire

Thank you for your interest in our practice. We ask new patients to complete this form. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, MI)**:**	**Date of Birth:**
Address:	**Phone Number:**
Date of last primary care visit:	
Who would you like to see? (Specify if preference. Leave blank if no preference):	

Main reason(s) you would like to be seen:	
Current medical conditions:	
Past medical conditions/ surgeries (no longer requiring treatment):	

Review of Systems – Please list briefly any current symptoms	
Skin:	Back or joints:
Head/Neck:	Intestinal:
Throat:	Bladder:
Lungs:	Circulation:
Chest/Heart:	Other:
Describe any recent changes in:	
Weight:	Energy level:
Mood:	Other concern:

Allergies to Medications		
Medication Name:	Reaction:	Comments:

Current medications- List all prescriptions, over the counter drugs, vitamins and supplements		
Name of Medication	Strength (Dose)	How often taken?
☐ I Do Not Take Any Medications. (Please initial box)		

_____ _____

Patient Signature **Date**