2831 Fort Missoula Rd.
Physicians Building #2, Suite 104
Missoula, MT 59804
406-926-1300 | YourMigraineCare.com

HEALTH HISTORY

PATIENT # _____

This history form provides us with information to help us meet all your healthcare needs, please complete both sides of this form answering each question. **This is a confidential part of your medical record and will be kept in this office.**

Today's Date: _____

Highest Level in School: _____

Occupation: _____

Exercise/Recreation: _____

Habits:

Smoking: (type and amount per day)_____ If former smoker, date quit _____

Alcohol: (type and amount per week) _____

Caffeine/Redbull: (type and amount per day) _____

All allergies (foods, drugs, environment):

_____

_____

_____

_____

_____

Have you ever had stitches: _____

When was your last physical exam? _____

Name of Doctor: _____ Phone: _____

Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred:

_____

_____

_____

Please list all medicines you are currently taking for headaches (include Nonprescription drugs):

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

Signature: _____ Date: _____

Physician's Comment:

Physician's Signature: _____ Date: _____