theSwierClinic

PATIENT HEALTH HISTORY

Dr Patrick Swier
1400 Savannah Road
Lewes, DE 19958

2600 Glasgow Ave, Suite 102
Newark, DE 19702

Pt Name: _____

Pt DOB: _____

Swier Clinic Acct # _____

PLEASE PRINT NEATLY

Primary Care Dr.: _____ **Cardiologist**: _____

Pharmacy Name/Location: _____ **Pain Mgmt Dr:** _____

Patient's Height: _____ **Patient's Weight:** _____

ALLERGIES (*list **ALL** allergies to medications, foods, adhesive tape, latex or list **NONE***)

_____ _____ _____

_____ _____ _____

MEDICATIONS (*list **ALL** medications you are currently taking, including OTC/Vitamins* or write **NONE**)
Do you have a written list? ___ Yes ___ No *If yes, please give to front desk so a copy can be made.*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PAST SURGERIES (list ***ALL*** surgeries, attach a written list or write **NONE**)

_____ _____ _____

_____ _____ _____

_____ _____ _____

PAST MEDICAL HISTORY: (Please check **ALL** that apply)

___ Asthma ___ Diabetes ___ Heart Disease ___ Heart Attack (Year _____)

___ Allergies ___ Cholesterol ___ High Blood Pressure ___ Stroke (Year _____)

___ Thyroid ___ Arthritis ___ Reflux ___ COPD/Emphysema

___ Migraines ___ Seizures ___ Kidney Disease ___ **NONE**

___ Cancer (Type _____) ___ other (list _____)

Do you smoke? __ NO __YES (how much per day? ____ppd) When did you quit? _____

I certify that the above information is true and correct to the best of my knowledge.

Patient Signature: (*or legal guardian, if minor*) _____ Date _____

Reviewed By MA/RN:

Initials Date

Verify health history every 3 months: _____ Pt initials/date _____ Pt initials/date _____ Pt initials/date

Reviewed by MA/RN every 3 months: _____ initials/date _____ initials/date _____ initials/date

Revised 07/17/2013

TODAY'S DATE _____ **EXP DATE:** _____ **Swier Clinic employee initials:** _____

Medical History is good for twelve (12) months UNLESS information changes