Health History Form - Yearly Update

Patient Name:_____ **Hospital Green Card #:**_____
D.O.B (dd/mm/yyyy):_____

Since your last visit to the clinic: Have you updated any contact information? o Yes o No
Home Address:_____

Phone Number: _____

Emergency Contact #:_____

Email Address: _____

Do you have any extended health care coverage? If yes with whom? o Yes o No

_____

\

Have there been any changes to your health? o Yes o No If yes, please specify:

_____

_____

Have you developed or discovered any new allergies? o Yes o No If yes, please specify:

_____

_____

Have you had any surgeries? o Yes o No If yes, please specify:

_____

_____

Have you been hospitalized? o Yes o No If yes, please specify:

_____

_____

Do you currently have, or have you recently had any infections? o Yes o No If yes, please specify:

_____

_____

Please list any current medications:

_____

_____

Date (dd/mm/yyyy) :_____ Signature: _____