Premier Orthopaedics and Sports Medicine
Victor Van Phan, D.O.

Patient Health History

In our effort to obtain a complete medical history, we ask that you complete this form as thoroughly as possible. This information is very important and it will become a part of your permanent health record. A copy is available upon request.

Patient Last Name: _____ First Name: _____ MI: _____

Sex: ☐Male ☐ Female Ethnicity: _____ D.O.B: _____

Street Address: _____ State: _____ Zip Code: _____

Best Contact Phone Number: _____ ☐ home ☐cell May we leave a voice message? ☐Yes ☐No
Email _____

Alternate Phone number: ***(please include the name of the person belonging to that #)_____***

Primary Care Doctor Name: _____ Primary Care Doctor #: _____

Referring Doctor Name:_____ Referring Doctor #_____

Reason for Today's Visit: _____

Pharmacy Name/Location: _____ Pharmacy Phone #: _____

Please list any medications/ vitamins / herbal supplements / topical creams you are currently taking. You may use the back of this page for more space or you may provide your own list.

Name	**Dosage**	**How often**	**How long**

Are you allergic to any medication or food? ☐ Yes ☐ No

Name of Allergy	**Reaction Type:** ***(nausea, vomiting, rash, itching, swelling, anaphylactic etc)***

Surgeries and Hospitalizations

Have you ever been hospitalized for non-surgical reasons? ☐Yes ☐No
If YES, please list why: _____

Please list all past surgeries and the year they were performed: _____
_____
Have you ever had any problems with any type of anesthesia? ☐ Yes ☐No
If yes, please list problems: _____
Have you seen a Physician since your last visit with us? ☐ Yes ☐ No