

**PPM Pennsylvania Pain Management**

**PATIENT HEALTH HISTORY INFORMATION**

All information provided will be kept **CONFIDENTIAL**.

Name	Date of Birth	DATE
------	---------------	------

**Please attach a separate sheet if necessary to provide the following information:**

1. Please list **ALL ALLERGIES** to food and/or medication


2. Please list **ALL MEDICATIONS** you are **currently taking**

MEDICATION	DOSE	FREQUENCY	DURATION

3. Please list **PRIOR MEDICATIONS**, when it was discontinued and the reason

MEDICATION	STOPPED	REASON (ie: didn't help, reaction, side effects etc)

4. Please list all **PREVIOUS SURGERIES** listing date, Hospital or Surgery Center and Surgeon

PROCEDURE	DATE(year)	FACILITY	SURGEON

5. Please list any **MRI, CAT SCAN, BONE SCAN etc**, test date, facility name, and ordering physician

TEST	DATE	FACILITY	DOCTOR

If you have had a reaction to anesthesia, please provide a brief description of the side effects.

Local	General