The Harmony Center Patient Health History

If you have a current list of medications/allergies and/or past surgeries and procedures, please attach with this form.

Patient Name_____ Date of Birth _____/_____/_____

Pharmacy Name_____ Phone _____

Pharmacy Address_____

Primary Care Physician_____ Phone_____

Current Medications

Medication Name Dosage How often taken

_____
_____
_____
_____
_____
_____
_____
_____

Medication Allergies

Medication Name Reaction

_____
_____
_____
_____

Surgeries & Procedures

Surgery Name Date

_____
_____
_____
_____