Lumicera Health Services

PATIENT HEALTH HISTORY FORM

Patient Information	
First & Last Name:	Date of Birth (MM/DD/YYYY):
Primary Address:	Secondary Address (Optional):
Preferred phone: ( ) ☐ Work ☐ Cell ☐ Home	Alternative phone: ( ) ☐ Work ☐ Cell ☐ Home
Emergency Contact Information	
Emergency Contact Name:	Relationship to Patient:
Emergency Contact Phone: ( ) ☐ Work ☐ Cell ☐ Home	Privacy Notes (*optional*):
Check the box if you do not want to add an emergency contact. ☐ *By checking the box, I decline to add an emergency contact to my patient profile.*	
Patient Health Information	
Weight (in pounds):	Height:
Are you pregnant, nursing or planning pregnancy (check one)? ☐ Yes ☐ No ☐ N/A	
Other health conditions:	
Allergies and Reaction (ex. Sulfa Medication Allergy with Hives):	

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Current Medications (include over-the-counter drugs and herbal supplements)					
Medication Name	**Date you started taking medication**	**Frequency**	**Dose**	**Route (oral, inhaled, injection, etc.)**	**Condition for which medication is prescribed**

Please fax or mail completed form to:
Lumicera Health Services
310 Integrity Drive
Madison, WI 53717
Fax: 855-847-3558

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