**PATIENT’S MEDICAL HISTORY**

**PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code:\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATIONS**

**Please list ALL the medications both prescription & over-the-counter,**

 **and any vitamins or minerals that you are currently taking**

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| --- | --- | --- |
| **Name** | **Strength** | **Direction** |
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**ALLERGIES**

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| --- | --- |
| **Name** | **Reaction** |
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**HISTORY OF PREVIOUS TESTING/ VACCINATIONS**

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| --- | --- | --- | --- |
| **TEST** | **YES** | **NO** | **REFUSED** |
| **SYPHILIS** |  |  |  |
| **GONORRHEA** |  |  |  |
| **CHLAMYDIA** |  |  |  |
| **HIV** |  |  |  |
| **Screening for Hepatitis C** |  |  |  |
| **Shingles Vaccination** |  |  |  |
| **Influenza Vaccination** |  |  |  |
| **Pneumonia Vaccination (Age 65 and older)** |  |  |  |
| **Gardasil (HPV)** |  |  |  |

**MEDICAL HISTORY**

|  |  |
| --- | --- |
| **List Major Injuries or Illnesses** | **Date** |
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**SURGICAL HISTORY**

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| --- | --- |
| **List Surgeries** | **Date** |
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**REVIEW OF SYSTEMS**

**Circle if you have any problems in the following areas:**

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| --- |
| **GENERAL/CONSTITUTIONAL**  (Fever, Heat Stroke, Weight Gain/Loss, Unusually Tired) |
| **CARDIOVASULAR**  (High Blood Pressure, Racing Pulse, Stroke) |
| **PULMONARY** (Congestion, Wheezing, Shortness of Breath) |
| **EARS, NOSE, MOUTH, THROAT**  (Chronic Sinusitis, Hearing Loss, Ringing in the Ears) |
| **EYES** (Poor Vision, Eye Pain, Tearing, Redness) |
| **GASTROINTESTIONAL** (Stomach Upset, Ulcers, Diarrhea, Constipation, Hernia) |
| **GENITAL, KIDNEY, BLADDER**  (Painful or Frequent Urination, Impotence, Jaundice) |
| **MUSCLE, BONES, JOINTS** (Joint Pain, Stiffness, Swelling, Arthritis, Cramps) |
| **INTEGUMENTARY/SKIN**  (Pimples, Warts, Rash, Lumps, Bumps) |
| **NEUROLOGIC** (Numbness, Headache, Seizures, Weakness, Paralysis) |
| **PSYCHIATRIC**  (Anxiety, Depression, Insomnia) |
| **ENDOCRINE** (Diabetes, Hyper/Hypothyroid) |
| **BLOOD/LYMPH**  (Bleeding, Anemia, Cholesterolemia, Trouble with Blood Transfusions) |
| **ALLERGIC/IMMUNOLOGIC** (Sneezing, Swelling, Redness, Itching, Hives, Lupus) |

**FAMILY HISTORY**

**Circle if any of your IMMEDIATE family members have problems in the following areas:**

|  |  |  |
| --- | --- | --- |
| **Disease** | **On your mother’s side:** | **On your father’s side:** |
| **Heart Disease** |  |  |
| **Stroke** |  |  |
| **Hypertension** |  |  |
| **Cataracts** |  |  |
| **Glaucoma** |  |  |
| **Diabetes** |  |  |
| **Thyroid Disease** |  |  |
| **Arthritis** |  |  |
| **Cancer** |  |  |

**SOCIAL HISTORY**

**Smoking History: Current \_\_\_\_\_\_\_ Former \_\_\_\_\_\_\_\_ Never \_\_\_\_\_\_\_\_**

**Do you presently use any of the following? YES NO**

|  |  |  |
| --- | --- | --- |
| **Chewing Tobacco** |  |  |
| **Cigarettes, Cigars or Pipe** |  |  |
| **Vaporless Cigarettes** |  |  |
| **Do You Live with Someone Who Smokes** |  |  |
| **Alcohol - If yes, Socially \_\_\_\_\_\_\_\_ Occasionally \_\_\_\_\_\_\_\_ Every day \_\_\_\_\_\_\_\_** |  |  |
| **Recreational Drugs** |  |  |
| **Drugs, If yes, daily** |  |  |
| **Do you or have you ever taken illicit Intravenous Drugs?**  |  |  |

**If you presently smoke, are you interested in quitting smoking? YES NO**

**Do you feel you have an alcohol addiction? YES NO**

**Patient's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**