

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Preferred Language: _____

PHARMACY PREFERENCE

Local Pharmacy Name: _____ Town: _____ Street: _____

PATIENT'S MEDICAL HISTORY (circle yes or no)

Alcohol/Drug Abuse	Yes	No	Cataract	Yes	No	Heart Attack	Yes	No	Nerve/Muscle Disease	Yes	No
Allergies (other than meds)	Yes	No	Circulation Problems	Yes	No	Heartburn/GERD/Ulcers	Yes	No	Osteoporosis	Yes	No
Anemia	Yes	No	Colitis/Bowel Disease	Yes	No	High Blood Pressure	Yes	No	Pneumonia	Yes	No
Anxiety	Yes	No	Congestive Heart Failure	Yes	No	HIV/AIDS	Yes	No	Seizures	Yes	No
Arthritis	Yes	No	Chronic Obstructive Pulmonary Disease	Yes	No	Jaundice	Yes	No	Sickle Cell	Yes	No
Asthma	Yes	No	Depression	Yes	No	Kidney Disease	Yes	No	Stroke	Yes	No
Birth Defect/Genetic Problem	Yes	No	Diabetes	Yes	No	Meningitis	Yes	No	Thyroid Disease	Yes	No
Blood Clots	Yes	No	Emphysema	Yes	No	Mental Health Problems	Yes	No	Tuberculosis	Yes	No
Blood Transfusion	Yes	No	Glaucoma	Yes	No	Murmur	Yes	No	Viral Hepatitis	Yes	No
Cancer	Yes	No	High Cholesterol	Yes	No	ADD/ADHD	Yes	No	Foot Problems?	Yes	No
Other Medical History: _____											

PATIENT'S SURGICAL HISTORY (circle yes or no)

Abdomen Surgery	Yes	No	Brain Surgery	Yes	No	C-Section	Yes	No	Hernia Repair	Yes	No
Appendectomy	Yes	No	Breast Surgery	Yes	No	Cholecystectomy (Gallbladder)	Yes	No	Hysterectomy	Yes	No
Surgical Repair: Broken Bones/Fractures	Yes	No	Colon Surgery	Yes	No	Adnoid/Tonsillectomy	Yes	No	Joint Replacement	Yes	No
Coronary Artery Bypass Graft	Yes	No	Cosmetic Surgery	Yes	No	Sterilization	Yes	No	Ear Tubes	Yes	No
Other Surgical History: _____											

PATIENT'S SOCIAL HISTORY for 10 YRS OLD and UP

Tobacco Use Packs/Day Quit Date	Yes		NEVER		Quit		Passive		Comment _____ Years of Smoking .5 1 2 3 4 5 10 other _____	
	.25	.5	1	1.5	2	3				

Alcohol Use Drinks/Week	Yes	No	Glass(es) of Wine					Comment _____		
	_____		Can(s) of Beer							
	_____		Shot(s) of Liquor							
	_____		Drinks containing 0.5 oz of alcohol							
Internal Drug Use Per Week	Yes	No	Comment _____							
	_____		Types		Marijuana		Methamphetamines			
	_____				Cocaine		IV			
Sexually Active Gender of Partners Birth Control/Protection:	Yes	No	Not Currently		Comment _____					
	Female		Male							
	Condom	Pill	Surgical	Spermicide						

OVER →

Please complete the form below relating to your family's medical history.

PLACE AN "X" IN THE APPROPRIATE BOX BELOW (see example)

PATIENT'S FAMILY HISTORY

Relationship	Name	Status	Cancer: Type and age of death (if applicable)	Diabetes-Type	Heart Failure	Hypertension (High Blood Pressure)	Asthma	High Cholesterol	Arthritis-Rheumatoid	Arthritis-Osteo	Stroke	Thyroid Disease	Seizures	Migraines	Rashes/Skin Problems	Other
Example	Sister	Sally	Alive/Deceased		X		X				X					
Parents	Mother		Alive/Deceased													
Parents	Father		Alive/Deceased													
Siblings			Alive/Deceased													
Siblings			Alive/Deceased													
Siblings			Alive/Deceased													
Siblings			Alive/Deceased													
Siblings			Alive/Deceased													
Patient's Children			Alive/Deceased													
Patient's Children			Alive/Deceased													
Patient's Children			Alive/Deceased													
Patient's Children			Alive/Deceased													
Grandparents	¹ MGM		Alive/Deceased													
Grandparents	¹ MGF		Alive/Deceased													
Grandparents	² PGM		Alive/Deceased													
Grandparents	² PGF		Alive/Deceased													

1: Maternal
2: Paternal

FEMALE

HEALTH MAINTENANCE	DATE
Last Pap Smear/Gyne Exam	
Last Mammogram	
Last Dexa Scan	
Last Colonoscopy	
Last Tdap/Tetnus	
Last Pneumovax	
Last Flu Shot	
Zostavax	

MALE

HEALTH MAINTENANCE	DATE
Last PSA	
Last Colonoscopy	
Last Tdap/Tetnus	
Last Pneumovax	
Last Flu Shot	
Zostavax	

Do you see other physicians? Yes No

Name _____

For what? _____

Name _____

For what? _____

Name _____

For what? _____

Name _____

For what? _____