CLINICAL HISTORY

PATIENT IDENTIFICATION

FIRST NAME: MIDDLE: LAST NAME: DATE OF BIRTH: / /

PHARMACY AND LOCATION:

PRIMARY PHYSICIAN:

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS

SYMPTOM:_______________________________ LOCATION:____________________ DURATION:______________________

DATE SYMPTOM(S) BEGAN: ___/___/___ RECENTLY SYMPTOM(S) HAVE BEEN: O MORE/O LESS FREQUENT O MORE/O LESS INTENSE
O CONTINUOUS O PERIODIC

HOW DID SYMPTOMS START:____

WHAT BRINGS IT ON:_______________________________________ WHAT RELIEVES IT:___________________________________

WHAT MAKES IT WORSE:____________________________________ ASSOCIATED SYMPTOMS:________________________________

MEDICATIONS – LIST ALL THE MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING "OVER THE COUNTER"

DRUG NAME	DOSAGE	FREQUENCY	REASON FOR TAKING

ALLERGIES- LIST ALL OF YOUR MEDICAL ALLERGIES AND THE REACTION

ALLERGIES	ALLERGIC REACTION

PAST MEDICAL HISTORY

LIST ALL ILLNESSES, INJURIES &OPERATIONS	DATE	TREATMENT	PHYSICIAN

FAMILY HISTORY- ALL BLOOD RELATIVES

LIST BLOOD RELATIVES ONLY	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH	ILLNESSES	SIMILAR SYMPTOMS?
MOTHER					
FATHER					
SIBLING(S)					