Name: ______________________ ____________ ______________ Sex: M F Date of Birth: ________ Age: ______
Last First Middle

Pharmacy Name: __________________________________ Pharmacy Telephone Number: ______________________

CURRENT MEDICATIONS

* Please include vitamins, over the counter meds, birth control pills, and herbal medications. Example: Lipitor 20 mg 1 tablet daily at night, etc.

NAME	**DOSAGE** -mg/units/puffs/drops	**FREQUENCY** - How many times per day? Morning and/or night? After meals?

Other Current Medications____

ALLERGIES TO MEDICATIONS/FOODS

____ **None** ______

Name of Medication/Food	**Allergic Reaction**	**Other Adverse reaction**	**Name of Medication/Food**	**Allergic Reaction**	**Other Adverse reaction**

PAST MEDICAL HISTORY

____ **None** ______

*Please write a check (√) if you have or you had any of the following.

	Anemia		Cancer – specify/ type ____________________		Heart Valve Problem		Prostate Problem
	Aneurysm		Depression- major/bipolar on meds?		Hepatitis		Seizures
	AIDS/HIV Positive		Diabetes Mellitus Pills/ insulin?		High Blood Pressure		Sexually Transmitted Disease/ Herpes/other
	Anxiety- on meds		Emphysema/ Chronic Bronchitis		High Cholesterol		Sleep Apnea
	Asthma		GERD/ reflux		Kidney Problem		Stroke/ TIA
	Atrial Fibrillation		Glaucoma – Right/Left?		Migraine Headache		Thyroid Problem
	Arthritis		Heart Attack		Osteoporosis		Other ____________________
	Blood Clot-lung/leg		Heart Failure		Pancreatitis		

Other Chronic Illness(es): ____

Patient Name:____ Date: ____________________

SURGICAL HISTORY/PROCEDURES *Please write a check (√) if applicable. ______________________________ None ______

TYPE	√	Month/Year
Abdominal Surgery		
Amputation (finger/toe/leg)		
Arthroscopy – Knee/ shoulder		
Appendix removal		
Back Surgery		
Biopsy (site)s		
Bladder Suspension		
Cataract Removal		
Colon Surgery- Removal		
Fracture/Bone Repair		
Heart Bypass/Valve Surgery		

TYPE	√	Month/Year
Hernia Repair		
Hysterectomy		
Joint Replacement		
Kidney Surgery		
Mastectomy		
Neck Surgery		
Thyroid Surgery		
Tonsillectomy		

PROCEDURE	√	Month/Year
Echocardiogram		
EGD Stomach Endoscopy		
Heart Cauterization With or without stent?		
Normal/Abnormal		
Stress Test		
Colonoscopy		
Normal		
Abnormal		
Polyps		
Diverticulitis		
Cosmetic Procedure		

FAMILY HISTORY *Please write a check (√) if applicable. ______________________________ None ______

	Father	Mother	Brother	Sister	Other
Alcoholism					
Alzheimer's/Dementia					
Aneurysm					
Arthritis					
Asthma					
Circulation Problem					
Coronary Artery Disease					
Heart Attack/Sudden Death					
Heart Failure					
Cancer:					
Bladder					
Breast					
Cervical					
Colon					
Kidney					
Esophagus					
Liver					
Lung					
Lymphoma					

	Father	Mother	Brother	Sister	Other
Cancer (continued):					
Ovarian					
Pancreas					
Prostate					
Stomach					
COPD/Lung Disease					
Depression/Nervous/ Emotional Disorder					
Diabetes					
Glaucoma					
High Blood Pressure					
High cholesterol					
Kidney Disease					
Migraine					
Osteoporosis					
Seizure					
Stroke					
Suicide					
Thyroid Problem					

SOCIAL HISTORY/LIFESTYLE *Please write a check (√) and complete the following if applicable.

MARITAL STATUS	Married_____ Single_____ Divorced_____ Widow_____ Legally Separated_____ No. of biological children_____
TOBACCO	Non-Smoker _____Smoker _____ Type: ______________________(cigars/ cigarettes/ other)
	How much per day? _________ For how long? _________ Date/Year Quit ___________ ____
	Uses Smokeless Tobacco? _________Yes _________ No
ALCOHOL	Non-Drinker _____ Yes_______ Please estimate your alcohol intake per week (1 unit = 12 oz beer or 1 glass of wine or 1 measures spirit). Number of units per week_________ Quit Drinking? _______ if yes, when?_______

IMMUNIZATION HISTORY *Please write a check (√) if you had any of the following immunizations and the most recent date/year it was administered.

	Yes	No	Date/ Year
Tetanus Diphtheria Booster *For everyone			
Influenza Vaccine (Yearly Flu Shot) *For everyone			
Pneumococcal Vaccine *For age >=65			
Other:			

Patient Name:____ Date: ________________