PREFERRED PHARMACY

Pharmacy Name _____

Address _____ City _____ State _____ Zip _____

Phone (_____)_____ Fax (_____)_____

MISCELLANEOUS INFO

Race (census bureau categorization)

□ American Indian & Alaskan Native
□ Asian
□ Black or African American
□ Black Hispanic or Latino
□ Native Hawaiian & Other Pacific Islander
□ White Hispanic or Latino
□ White
□ *Decline to state*

Language Preference

□ English □ Chinese □ French □ German
□ Italian □ Japanese □ Korean □ Portuguese
□ Russian □ Spanish □ *Decline to state*

How did you find us? _____

I hereby give lifetime authorization for payment or insurance benefits to be made directly to the physician and any assisting physicians for services rendered. I understand that I am financially responsible for all charges, whether they are covered or not covered by my insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ _____ _____

Signature of Responsible Party Print Patient's Name Date

HEALTH HISTORY

(Confidential)

Your answers on this form will help your health care provider better understand your medical concerns, conditions and health goals. This form will not be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. Thank you!

Name _____ Today's Date _____ Age _____

Date of Birth _____/_____/_____ Date of Last Physical Exam _____/_____/_____

What is the reason for your visit? _____

SYMPTOMS (Please check any current symptoms you have)

GENERAL
- □ Chills
- □ Depression
- □ Dizziness
- □ Fainting
- □ Fever
- □ Forgetfulness
- □ Headache
- □ Lack of sleep
- □ Loss of weight
- □ Nervousness
- □ Numbness
- □ Sweats

MUSCLE/JOINT/BONE
- □ Pain, weakness, numbness in:
  - □ Arms
  - □ Hips
  - □ Back
  - □ Legs
  - □ Feet
  - □ Hands
  - □ Neck
  - □ Shoulders

GENITO-URINARY
- □ Blood in urine
- □ Frequent urination
- □ Painful urination

GASTROINSTESTINAL
- □ Poor appetite
- □ Bloating
- □ Bowel changes
- □ Constipation
- □ Diarrhea
- □ Excessive hunger
- □ Excessive thirst
- □ Gas
- □ Hemorrhoids
- □ Indigestion
- □ Nausea
- □ Rectal bleeding
- □ Stomach pain
- □ Vomiting
- □ Vomiting blood

CARDIOVASCULAR
- □ Chest pain
- □ High blood pressure
- □ Irregular heart beat
- □ Low blood pressure
- □ Poor circulation
- □ Rapid heart beat
- □ Swelling of ankles
- □ Varicose veins

EYES, EARS NOSE, THROAT
- □ Bleeding gums
- □ Blurred vision
- □ Crossed eyes
- □ Difficulty swallowing
- □ Double vision
- □ Ear ache
- □ Ear discharge
- □ Hoarseness
- □ Loss of hearing
- □ Nosebleeds
- □ Persistent cough
- □ Ringing in ears
- □ Sinus problems
- □ Vision-flashes
- □ Vision-halos

SKIN
- □ Bruise easily
- □ Hives
- □ Itching
- □ Change in moles
- □ Rash
- □ Scars
- □ Sore that won't heal

MEN ONLY
- □ Breast lump
- □ Erection difficulties
- □ Lump in testicles
- □ Penis discharge
- □ Sore on penis
- □ Other:

WOMAN ONLY
- □ Abnormal PAP smear
- □ Bleeding between periods
- □ Breast lump
- □ Extreme menstrual pain
- □ Hot flashes
- □ Nipple discharge
- □ Painful intercourse
- □ Vaginal discharge
- □ Other:

Date of last menstrual period:

_____/_____/_____

Date of last PAP:

_____/_____/_____

Date of last mammogram:

_____/_____/_____

Are you pregnant?
□ Yes □ No

Number of children: _____

CONDITIONS (Check conditions you have or have had in the past)

□ Aids	□ Chemical dependency	□ High cholesterol	□ Prostate problem
□ Alcoholism	□ Chicken pox	□ HIV positive	□ Psychiatric care
□ Anemia	□ Diabetes	□ Kidney disease	□ Rheumatic fever
□ Anorexia	□ Emphysema	□ Liver disease	□ Scarlet fever
□ Appendicitis	□ Glaucoma	□ Measles	□ Stroke
□ Arthritis	□ Goiter	□ Migraine headaches	□ Suicide attempt
□ Asthma	□ Gonorrhea	□ Miscarriage	□ Thyroid problems
□ Bleeding disorders	□ Gout	□ Mononucleosis	□ Tonsillitis
□ Breast lump	□ Heart disease	□ Multiple sclerosis	□ Tuberculosis
□ Bronchitis	□ Hepatitis	□ Mumps	□ Ulcers
□ Bulimia	□ Hernia	□ Pacemaker	□ Vaginal infections

MEDICATIONS YOU ARE CURRENTLY TAKING	***ALLERGIES TO MEDICATIONS OR SUBSTANCES***

HEALTH HABITS (Check which substances you use and describe how much/how often)

□ Caffeine _____

□ Tobacco _____

□ Drugs _____

□ Other _____

OCCUPATIONAL CONCERNS (Check if your work exposes you to the following):

□ Stress
□ Hazardous substance
□ Heavy lifting
□ Other _____

Your Occupation: _____