

PLEASE PRINT

Adult (over 18yrs) **Minor (0-17yrs)**

Patient's Full Name: (Last) _____ (First) _____ (M.I.) _____

Date of Birth: ____ / ____ / ____ **Today's Date:** ____ / ____ / **2010**

How did patient hear about our office? _____

Pharmacy Name: _____ **Pharmacy Location:** _____

Please list the main concern that patient would like addressed today:

General Medical History: Check here if NONE

Mark X If Positive	Medical Problem	Year Started	Resolved Y/N	Mark X If Positive	Medical Problem	Year Started	Resolved Y/N
	Heart disease				Blood Clots		
	Heart valve disease				Cancer		
	Heart attack				Chronic Back pain		
	Heart stent placement				Fractures		
	High blood pressure				Arthritis - Degenerative		
	High Cholesterol				Arthritis - Rheumatoid		
	High Triglycerides				Lupus		
	Varicose Veins				Osteoporosis		
	Asthma				Osteopenia		
	COPD				Type 1 Diabetes		
	Respiratory Disease				Type 2 Diabetes		
	Allergies				Hyperthyroidism		
	Bronchitis				Hypothyroidism		
	Sinusitis				Migraine Headaches		
	Chron's Disease				Stroke / CVA		
	Colon Polyps				Shingles		
	Diverticulitis				Kidney Disease		
	Gall Stones				Anorexia		
	Hemorrhoids				Anxiety		
	Hepatitis A				Bipolar disorder		
	Hepatitis B				Bulimia		
	Hepatitis C				Depression		
	Irritable Bowel Disease				Epilepsy		
	Liver disease				Schizophrenia		
	Rectal Bleeding				Tonsillectomy		
	Ulcerative Colitis				Appendectomy		
	Anemia				Gall bladder removal		
	Bleeding disorder						

Specialists and Physicians Seen in the past 10 years: Check here is NONE

Surgical History: Check here if NONE

Please list any and all surgeries the patient has had and the approximate years

Allergies: Please list the reactions when patient took the medication

Medications: Include over the counter medications, vitamins, and dosages

Social History:

Do you smoke? Yes / No

Packs / day _____, _____ years

Quit? Yes / No When? _____

Do you drink alcohol? Yes / No Drinks / day _____

Do you use recreational drugs? Yes / No Types _____

Do you drink caffeine? Yes / No

Do you wear your seatbelt? Yes / No

What type of work do you do? _____

Do you exercise? Yes / No Type _____, _____ days / week

Are you Married, Single, Divorced, Widowed?

Do you have any children? Yes / No _____ Children

Do you have any pets? Yes / No

Type _____

Do you travel out of the country? Yes / No

Have you had Travel Vaccines? Yes / No

Family History - Circle Appropriately

- | | |
|------------------|----------------------------|
| Alcoholism | Heart disease |
| Thyroid disorder | Heart attack <50 years old |
| Breast Cancer | Heart attack >50 years old |
| Cancer | High blood pressure |
| Colon Cancer | Stroke |
| Diabetes | Elevated Cholesterol |

Other _____

Review of systems: Please circle any of the following patient is experiencing today

- fever, night sweats, malaise, weight gain, weight loss
- rash, itching, dryness, suspicious lesions
- hearing loss, ringing in ears, runny nose, hoarseness
- blurry vision, double vision, eye irritation, eye discharge, vision loss, eye pain, light sensitivity
- cough, shortness of breath, excessive sputum, spitting up blood, wheezing
- chest pains, palpitations, passing out, shortness of breath on exertion, propping yourself up at night, swelling of the arms or legs
- trouble swallowing, abdominal pain, nausea, vomiting, stool changes
- excessive urination, excessive thirst, heat or cold intolerance
- urinary hesitancy, urinary dribbling, sexual problems, genital problems, blood in the urine, painful urination, urinary frequency, kidney stones
- hives, allergies, persistent infections, HIV exposure
- abnormal bruising, bleeding, enlarged lymph nodes
- back pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness, arthritis
- headache, weakness, numbness, memory loss, slurring, shaking
- suicidal thoughts, sleeping problems, depression, anxiety, hallucination

Previous diagnostic testing: Please indicate an approximate date

Colonoscopy_____	Stress Test_____
DEXA Bone Scan_____	ECHO_____
Mammogram_____	Carotid US_____
Pap Smear_____	Lower Extremity US _____
PSA_____	Cholesterol level_____
Tetanus Shot_____	Routine blood test_____
Pneumonia Shot_____	Eye exam_____
Flu Shot_____	Hearing test_____
Chest X-ray_____	ECG_____
Pulmonary function Test_____	