PATIENT'S MEDICAL HISTORY

PHARMACY: _____ Zip code:_____Phone:_____

MEDICATIONS

Please list ALL the medications both prescription & over-the-counter,

and any vitamins or minerals that you are currently taking

Name	Strength	Direction

ALLERGIES

Name	Reaction

HISTORY OF PREVIOUS TESTING/ VACCINATIONS

TEST	YES	NO	REFUSED
SYPHILIS			
GONORRHEA			
CHLAMYDIA			
HIV			
Screening for Hepatitis C			
Shingles Vaccination			
Influenza Vaccination			
Pneumonia Vaccination (Age 65 and older)			

MEDICAL HISTORY

List Major Injuries or Illnesses	Date

SURGICAL HISTORY

List Surgeries	Date

REVIEW OF SYSTEMS

Circle if you have any problems in the following areas:

GENERAL/CONSTITUTIONAL (Fever, Heat Stroke, Weight Gain/Loss, Unusually Tired)
CARDIOVASULAR (High Blood Pressure, Racing Pulse, Stroke)
PULMONARY (Congestion, Wheezing, Shortness of Breath)
EARS, NOSE, MOUTH, THROAT (Chronic Sinusitis, Hearing Loss, Ringing in the Ears)
EYES (Poor Vision, Eye Pain, Tearing, Redness)
GASTROINTESTIONAL (Stomach Upset, Ulcers, Diarrhea, Constipation, Hernia)
GENITAL, KIDNEY, BLADDER (Painful or Frequent Urination, Impotence, Jaundice)
MUSCLE, BONES, JOINTS (Joint Pain, Stiffness, Swelling, Arthritis, Cramps)
INTEGUMENTARY/SKIN (Pimples, Warts, Rash, Lumps, Bumps)
NEUROLOGIC (Numbness, Headache, Seizures, Weakness, Paralysis)
PSYCHIATRIC (Anxiety, Depression, Insomnia)
ENDOCRINE (Diabetes, Hyper/Hypothyroid)
BLOOD/LYMPH (Bleeding, Anemia, Cholesterolemia, Trouble with Blood Transfusions)
ALLERGIC/IMMUNOLOGIC (Sneezing, Swelling, Redness, Itching, Hives, Lupus)

FAMILY HISTORY

Circle if any of your IMMEDIATE family members have problems in the following areas:

Disease	On your mother's side:	On your father's side:
Heart Disease		
Stroke		
Hypertension		
Cataracts		
Glaucoma		
Diabetes		
Thyroid Disease		
Arthritis		
Cancer		

SOCIAL HISTORY

Smoking History: **Current _____** **Former _____** **Never _____**

Do you presently use any of the following?	YES	NO
Chewing Tobacco		
Cigarettes, Cigars or Pipe		
Vaporless Cigarettes		
Do You Live with Someone Who Smokes		
Alcohol - If yes, Socially _____ Occasionally _____ Every day _____		
Recreational Drugs		
Drugs, If yes, daily		
Do you or have you ever taken illicit Intravenous Drugs?		

If you presently smoke, are you interested in quitting smoking? **YES** **NO**

Do you feel you have an alcohol addiction? **YES** **NO**

Patient's Signature: _____ Date: _____