**ESTABLISHED 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 2019** |  |  |  |
| **Gonorrhea 2019** |  |  |  |
| **Chlamydia 2019** |  |  |  |
| **HIV (Unless you Opt-Out from being tested, you will have a HIV test done, when you have blood drawn in our office).** |  |  | **Opt Out** |
| **Screening for Hepatitis C** |  |  |  |
| **Shingrix Vaccination (Age 50 and older)** |  |  |  |
| **Influenza Vaccination** |  |  |  |
| **Pneumonia Vaccination (Age 65 and older)** |  |  |  |
| **Gardasil (HPV)** |  |  |  |

**MEDICAL HISTORY**

|  |  |
| --- | --- |
| **List Major Injuries or Illnesses** | **Date** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**SURGICAL HISTORY**

|  |  |
| --- | --- |
| **List Surgeries** | **Date** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**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**

|  |  |  |
| --- | --- | --- |
| **Tobacco** |  |  |
| Chewing Tobacco |  |  |
| Cigarettes, Cigars or Pipe |  |  |
| Vaporless Cigarettes |  |  |
| Do You Live with Someone Who Smokes |  |  |
|  |  |  |
| **Recreational Drugs** |  |  |
| Drugs |  |  |
| Do you use drugs on a daily basis? |  |  |
| Do you or have you ever taken illicit Intravenous Drugs? |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

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

**Patient's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**