Appointment Date: ____________________ Date of Birth: ______________________

Last Name: ________________________ First Name: __________________________

Pharmacy

Family Physician

Referring Physician

What is the reason for your visit today?

How long has this problem been going on?

Current medications including dosage: (Do you take Aspirin (Anti-Inflammatory), Coumadin (Anti-Coagulation), or Vitamin E? -please note below)

Do you have allergies to medications including reaction? Latex?

Current Health

Do you currently have any of the following medical problems?

- Chills
- Fatigue
- Fever
- Weight Loss
- Weight Gain
- Ear Drainage
- Ear Pain
- Eye Discharge
- Eye Pain
- Hearing Loss
- Nasal Drainage
- Sinus Pressure
- Sore Throat
- Visual Changes
- Cough
- Shortness of Breath
- Hemoptysis (Coughing Blood)
- Snoring
- Wheezing
- Chest Pain
- Palpitations
- Heartburn/Reflux
- Nausea
- Vomiting
- Hematuria (Blood in Urine)
- Urinary Retention
- Heat Intolerance
- Cold Intolerance
- Tremors
- Anxiety
- Depression
- Insomnia
- Hives
- Mole Changes
- Rash
- Skin Lesion
- Joint Swelling
- Muscle Weakness
- Neck Pain
- Easy Bleeding
- Easy Bruising
- Enlarged Lymph Nodes

- Hoarseness
- Food Sticking
- Visual Loss
- Epistaxis (Nose Bleed)
- Facial Pain
- Other: ______________
- Dizziness
- Gait Disturbance
- Headache
- Memory Loss
- Seizures
- Contact Allergy
- Environmental Allergies
- Food Allergies
- Seasonal Allergies
- Ringing/Tinnitus

Last Name: ____________________ First Name: ________________________

Surgical History

☐ Never had surgery

☐ Any complications? Anesthesia complications? [ ]

Hospitalization History

☐ Never been hospitalized

	Procedure(s)/Hospitalizations	Year		Procedure(s)/Hospitalization(s)	Year
1			1		
2			2		
3			3		
4			4		
5			5		
6			6		

Past Medical History and Family History *Please indicate only close (1st degree) relationships (i.e. mother, father, brother, sister) only.

Self	Relative	Condition	Self	Relative	Condition	Self	Relative	Condition
○		Asthma	○		Heart Disease	○		Lupus
○		Anemia	○		Hypertension	○		Thyroid
○		Arthritis			Migraines	○		Other: ________________
○		Bleeding Disorder	○		Kidney Disorder	○		Hepatitis ________
○		Cancer-Type: ________________	○		Seizure	○		MRSA Site: ____________ Date: ____________
○		Diabetes	○		Stroke			
○		GERD/Reflux	○		Renal Disease			
○		Allergies	○		Mental Disease			

Are your parents alive or deceased?

Mother ☐ Alive ☐ Deceased ☐ Unknown

Father ☐ Alive ☐ Deceased ☐ Unknown

Are you adopted ☐ Yes

Smoking Status

☐ Current every day ☐ Current some days ☐ Former ☐ Never ☐ Unknown

Type: ☐ Cigarettes ☐Chew ☐ Other [ ] Units/day [ ]

Ever tried to quit? ☐ Yes ☐ No Passive smoke exposure? ☐Yes ☐ No

Longest tobacco free [ ] Age started [ ] Age Quit [ ]

Alcohol Status

Drinks alcohol ☐ Yes ☐ No ☐ Former

Do you wear glasses? ☐ Yes ☐ No Do you wear hearing aid(s) ? ☐ Yes ☐ No

Social History

Occupation [ ]

Illegal Drug Status

Use drugs ☐ Yes ☐ No ☐ Former Type [ ] Frequency [ ]

Do you have a history of or do you have HIV? ☐ Yes ☐ No