

Patient History Form

PLEASE MAIL THIS COMPLETED FORM TO US BEFORE YOUR SCHEDULED APPOINTMENT OR YOUR APPOINTMENT MAY NEED TO BE RESCHEDULED.

Name: _____ **D.O.B** _____

Preferred Pharmacy name and phone #: _____

Profession/Student: _____ **Marital Status** (circle one) S M D W

Spouses Name: _____

Children's Names: _____ **Year of birth** _____

Vaccine	Year of last
Tetanus	
Influenza	
Pneumonia	
Shingles	

ALLERGIES OR ADVERSE DRUG REACTIONS?

(Please list drug and type of reaction below)

Social History

Do you drink caffeinated beverages?

Cups per day? _____

Do you smoke? Y N Number packs per day _____

Do you drink alcohol? Y N Number per week _____

Do you have a history of illicit/illegal drug use? Y N if yes, please list _____

FAMILY HISTORY:

Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives; for "other" write relation.

Illness/Condition	Family Member						
	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer							
Breast cancer							
Other cancer; Type:							
Heart disease							
Diabetes; Type:							
High blood pressure							
Liver disease; Type:							
High cholesterol							
Alcohol or Drug Abuse (circle one)							
Depression							
Bipolar							
Genetic (inherited) disorder; Type:							
Digestive Disease; Type:							
Other							

Your Past Medical History

Do you now or have you ever had: (check if "yes" and please write in the year that you were diagnosed with these)

- Cancer, Type _____ Heart problems, Explain _____
- Kidney disease Cataracts L or R High cholesterol COPD
- Pneumonia, When _____ Anemia HIV/AIDS Goiter
- Diabetes Type _____ Stomach ulcers Emphysema Glaucoma

