PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form.

Patient's Last Name ______________________ **First** ______________________ **M.I.** ________

Sex: ☐ Male ☐ Female **Date of Birth:** ______________ **Height** ____________ **Weight** ____________

Pharmacy Name: ______________________________ **Phone Number:** ______________________

Pharmacy Address: ____

REASON FOR TODAY'S VISIT: ____

	YES	NO
Arthritis	____	____
Bleeding Tendency	____	____
Cancer	____	____
Describe Type ______________		
Neurological		
Seizures (Epilepsy)	____	____
Last seizure (when?) ______________		
Stroke/TIA	____	____
Numbness	____	____
Area of Numbness		
Arms	____	____
Legs	____	____
Respiratory		
Asthma	____	____
Wheezing	____	____
Bronchitis	____	____
Cough	____	____
Frequent	____	____
Occasional	____	____
Congestion	____	____
Frequent	____	____
Occasional	____	____
Emphysema	____	____
COPD	____	____
Pneumonia	____	____
Sleep Apnea	____	____
Snoring	____	____
Sore Throat	____	____
Stiff Neck or Jaw	____	____
Trach./Ventilator	____	____

	YES	NO
Gastrointestinal		
Hepatitis	____	____
Liver Disease	____	____
Jaundice	____	____
Trouble Swallowing	____	____
Heartburn	____	____
Hiatal Hernia	____	____
Blood in Stool	____	____
Ear Problems		
Ache/Pain	____	____
Drainage	____	____
Blood	____	____
Clear	____	____
Hearing Loss		
Right Ear	____	____
Left Ear	____	____
Ringing in Ear	____	____
Vertigo	____	____
Cardiac		
Rheumatic Fever	____	____
Heart Murmur	____	____
Palpitations	____	____
Irregular Heartbeat	____	____
Heart Attack	____	____
Chest Pain	____	____
Shortness of Breath	____	____
Heart Failure	____	____
Hypertension	____	____
Coronary Artery Disease	____	____
High Cholesterol/Triglycerides	____	____
Did you have the pneumonia vaccine?	____	____

	YES	NO
Childhood Diseases		
Chicken Pox	____	____
Measles	____	____
Mumps	____	____
Headaches		
Frequent	____	____
Occasional	____	____
Sinus	____	____
Migraine	____	____
Psychiatric		
Anxiety	____	____
Depression	____	____
Bipolar	____	____
Attention Deficit	____	____
Schizophrenia	____	____
Suicidal	____	____
Congenital Disorders		
Downs Syndrome	____	____
Autism Spectrum	____	____
Other:		
Endocrine		
Kidney Disease	____	____
Diabetes Type I	____	____
Diabetes Type II	____	____
Thyroid Problem	____	____
Prednisone Treatment	____	____
Other Steroids	____	____
HIV	____	____

Allergies

Medication Allergies: ______________________ Food Allergies: ______________________

Environmental Allergies: ______________________ Latex Allergy: ❑ YES ❑ NO

Current Medications

Name and Dose of Current Medication(s) (Include all over the counter medicine):

Drug Name: Indicate Generic or Brand Name, mg. and dosage	Times Given Be specific AM/PM	Drug Name: Indicate Generic or Brand Name, mg. and dosage	Times Given Be specific AM/PM
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Home Oxygen: ❑ YES ❑ NO

Do you take aspirin or any medicine that has aspirin in it? ❑ YES ❑ NO (Anacin, Bufferin, Cold Remedies, etc.)

First Name:______________________________ Last Name:__________________________ M.I. _____ Age_____DOB____________

Social History

Education: How many years of school have you completed? ______________________________

Occupation: Your current employment status: ❑Retired ❑Unemployed ❑Homemaker ❑Employed – current occupation(s): ______________

Previous Occupations/Jobs: ______________________________

Disability: Are you disabled? ❑No ❑Yes → ______________________________

Have you used any of the following substances?

Substance	Currently Use?	Previously Used?	Type/Amount/Frequency	How Long? (Years)	If Stopped, when? (Year)
Caffeine: coffee, tea, soda	❑No ❑Yes	❑No ❑Yes			
Tobacco	❑No ❑Yes	❑No ❑Yes			
Alcohol – beer, wine, liquor	❑No ❑Yes	❑No ❑Yes			
Recreational/Street drugs	❑No ❑Yes	❑No ❑Yes			

Please answer if patient is under the age of 18

Does anyone in the household smoke? ❑No ❑Yes

Does the child go to daycare or pre-school? ❑No ❑Yes If yes, number of days per week ______________________.

School age children: current grade ________________.

Parental involvement: Mother and Father involved? ❑No ❑Yes

If joint custody: Primarily lives with ❑Mother ❑Father ❑Other ______________________________

Surgery: List type and approximate year of surgery.

Type	Year

Do you have parts of your medical history that you only wish to discuss with the doctor? ❑No ❑Yes

Do you have any other medical problems not covered on this form. Please explain.

____

Family History

Illness/Condition	Father	Mother	Brothers	Sisters	Sons	Daughters	None	Describe
Cancer (describe the type of cancer for each person)								
Heart Disease								
Diabetes								
Stroke/TIA								
High Blood Pressure								
High Cholesterol or Triglycerides								
Liver Disease								
Alcohol or Drug Abuse								
Anxiety, Depression or Psychiatric Illness								
Tuberculosis								
Anesthesia Complications								
Genetic Disorder								
Hearing Loss								
Sleep Apnea								
Bleeding Disorders								
Allergies								

(Father, Mother, Brothers, Sisters, Sons, Daughters, None are grouped under "Family Members")

______________________________ Signature of Patient, Guardian or Parent

______________________________ Date