**MEDICAL HISTORY FORM**

**Name: DOB: DATE:**

**Chief Complaint:**

**Pharmacy Phone #: \_\_\_\_\_\_\_\_\_**

**Pharmacy Name:**

**Pharmacy Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy Fax#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
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|  |  |
|  |  |

**MEDICATIONS: (Strength and Frequency)**

**1**

**4**

**2**

**5**

**3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **6\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALLERGIES**:

**SURGICAL HISTORY:**

**1**

**Date of Surgery**

**Name of Surgery**

**1**

**2**

**2**

**3**

**3**

**4**

**4**

**PERSONAL MEDICAL HISTORY: (Yes/No)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Acid Reflux** |  | **Gout** |  | **Pneumonia** |  |
| **Anemia** |  | **Heart Attack** |  | **Polio** |  |
| **Arthritis** |  | **Heart Disease/Failure** |  | **Rheumatic Fever** |  |
| **Asthma** |  | **Hepatitis** |  | **Sickle Cell Disease** |  |
| **Back Trouble** |  | **HIV+/AIDS** |  | **Skin Disorder** |  |
| **Bladder Infections** |  | **High Blood Pressure** |  | **Sleep Apnea** |  |
| **Abnormal Bleeding** |  | **Kidney Disease** |  | **Stomach Ulcers** |  |
| **Blood Clots** |  | **Liver Disease** |  | **Stroke** |  |
| **Blood transfusion** |  | **Low blood pressure** |  | **Thyroid Disease** |  |
| **Bronchitis/Emphysema** |  | **Migraine Headaches** |  | **Tuberculosis** |  |
| **Cancer** |  | **Mitral Valve Prolapse** |  | **Fibromyalgia** |  |
| **Diabetes: Type 1 or Type 2 (circle)** |  | **Neuropathy** |  | **Open Sores** |  |
| **Other Conditions:**  |  |

|  |
| --- |
| **Family History: (Please list any health problems and cause of death, age, etc)** |
| **Father: Age:** |  |
| **Mother: Age:** |  |
| **Siblings:** |  |
| **Grandparents – Mother:** |  |
| **Grandparents – Father:** |  |

**Social History:**

Do you use recreational Drugs?? **YES / NO** What kind?

Do you drink ALCOHOL? **YES / NO** What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you SMOKE? **YES / NO** How Many? Cigarettes **or** packs Per Day **or** week

Do you want to quit? **YES / NO**

Do you consume caffeinated beverages? **YES / NO** What kind? \_\_\_\_\_\_\_\_

Frequency? \_\_\_\_\_\_ Per Day or Week or Month (please circle one)

Do you have difficulty sleeping? **YES / NO** Snoring? **YES / NO**