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PATIENT MEDICAL HISTORY

Patient Name:_____ Today's Date:_____ Date of Birth:_____

CHECK ANY THAT YOU ARE CURRENTLY BEING TREATED FOR OR HAVE HAD IN THE PAST:

	Heart Disease		Anemia or Other Blood Disease		Severe Headaches		Neck Pain
	High Blood Pressure		Thyroid Disease		Seizures		Back Pain
	High Cholesterol		Stomach Disease		Stroke		Sleep Apnea
	Lung Disease		Kidney,Bladder,or Prostate Disease		Blood Clots		Other_____
	Diabetes		Cancer (past/present)		Depression		

ALLERGIES: (medications, food, latex and environmental)

1._____ Severity: _____ Reaction:_____

2._____ Severity: _____ Reaction: _____

3. _____ Severity: _____ Reaction: _____

CURRENT MEDICATIONS: (include non-prescription products)

1._____ 2._____ 3._____ 4._____

5._____ 6._____ 7._____ 8._____

PREFERRED PHARMACY:

Pharmacy Name:_____ Location:_____

PROCEDURES/SURGERIES:

Procedure/Surgery: _____ Approx. Date: _____

Procedure/Surgery: _____ Approx. Date: _____

Procedure/Surgery: _____ Approx. Date: _____

Procedure/Surgery: _____ Approx. Date: _____

PREVENTATIVE SCREENING:

Colonoscopy: YES NO If YES, date: _____

Mammogram: YES NO If YES date: _____

WOMEN'S HEALTH:

When was your last menstrual cycle? Date:_____

FAMILY HISTORY:

Mother:	High Blood Pressure	Diabetes	Cancer	Other (please specify) _____
Father:	High Blood Pressure	Diabetes	Cancer	Other (please specify) _____
Sister:	High Blood Pressure	Diabetes	Cancer	Other (please specify) _____
Brother:	High Blood Pressure	Diabetes	Cancer	Other (please specify) _____
Grandmother(M):	High Blood Pressure	Diabetes	Cancer	Other (please specify) _____
Grandfather(F):	High Blood Pressure	Diabetes	Cancer	Other (please specify) _____
Grandmother(M):	High Blood Pressure	Diabetes	Cancer	Other (please specify) _____
Grandfather(F):	High Blood Pressure	Diabetes	Cancer	Other (please specify) _____

OTHER HEALTH ISSUES:

Do you drink alcohol? YES NO Beer Wine Liquor _____ per week.

Do you smoke cigarettes? YES NO If YES, _____ per day, _____years of use.

Do you use other forms of tobacco? YES NO Pipe Cigar Snuff/Chew

Do you use an e-cigarette? YES NO If YES, _____ per day, _____years of use.

Marijuana/recreational drug use? YES NO If YES, _____ per day, _____years of use.

IMMUNIZATIONS:

Influenza (18 years of age and older)? YES NO If YES, date:_____

Pneumococcal (65 years of age and older)? YES NO If YES, date: _____

Tetanus YES NO If YES, date:_____