Patient Medical History (18+ Years)

Name: _____ DOB: _____Date: _____

Preferred Method of Communication: ☐ Phone ☐ Mail ☐ E-mail ☐ Text

Advanced Directive/Living Will: Yes ☐ No ☐

Occupation: Employer _____ Job Title _____

Pharmacy Name: _____ Phone Number: _____

Habits: Please circle all that apply.

Smoking:	Never	Former	Presently	# of packs/day _____
Alcohol:	None	Rarely	Occasionally	Socially
Drug Use:	None	Former	Presently	Type:
Caffeine:	None	1-2 cups/day	3-4 cups/day	More than 5 cups/day
Exercise:	None	Intermittently	Regularly	

Current Medication List: Please include any over the counter drugs, herbal supplements, vitamins, and birth control.

☐ No Current Medications

Medication	Dosage (mg)	Frequency	Prescribing Physician

Allergies: Please include food, drug, and environmental allergies.

☐ No Known Allergies

Allergy	Interaction	Allergy	Interaction

Previous Surgery History:

☐ No Past Surgical History

Surgery	Year	Complications?

Personal Medical History: Please check all that apply.

☐ No Relevant Medical History

Diagnosis	Past	Current	Diagnosis	Past	Current
Anemia			High Blood Pressure		
Angioplasty/stent			High Cholesterol		
Anxiety			Kidney Disease		
Arthritis/Joint Pain			IBS (irritable bowel syndrome)		
Asthma			Jaundice		
Blood Clot/DVT			Kidney Disease		
Blood Transfusion			Liver Disease		
Cancer – list type:			Migraines		
COPD			Osteoporosis		
Depression			Pacemaker		
Diabetes – list type:			Seizures		
Fibroids			Sexually Transmitted Disease – specify:		
GERD			Stroke		
Heart Disease			Thyroid		
Heart Attack			Tuberculosis		
Hepatitis – specify A,B,C:			Ulcers		

Relevant FAMILY Medical History: Please indicate whether relative is Living or Deceased.

☐ No Relevant History

	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandmother	Aunts/ Uncles
Cancer									
Diabetes									
High Blood Pressure									
Heart Attack									
Heart Disease									
Blood Clots/DVT									
Stroke									
Mental Illness									
Drug/Alcohol Addiction									
Other Diseases Not Mentioned									
Living/Deceased									

Health Maintenance Screenings: Please circle all that apply.

Colonoscopy	Yes No	Date:	Results:	Normal	Abnormal
FIT/Stool Test	Yes No	Date:	Results:	Normal	Abnormal
Mammogram	Yes No	Date:	Results:	Normal	Abnormal
PAP Smear	Yes No	Date:	Results:	Normal	Abnormal

Immunization History: Have You Had:

Hepatitis B Series	Yes	No	Date:	# of Doses if Known:	
TDaP/Tetanus	Yes	No	Date:		
Pneumovax 23	Yes	No	Date:		
Prevnar (Pneumo 13)	Yes	No	Date:		
Flu	Yes	No	Date:		

Lifestyle:

Support Person #1:_____ Support Person #2:_____

Military Experience: ☐ Yes ☐ No Education: (Highest grade completed) _____

Hobbies/Activities: _____

Religion: _____

Have you recently Traveled outside the area? ☐ Yes ☐ No If yes, where? _____

Residence Information:

Housing Status: _____

Smoke Detectors: ☐ Yes ☐ No Firearms in the Home: ☐ Yes ☐ No

Have you ever been a victim of abuse or domestic violence? ☐ Yes ☐ No

Do you feel safe at home? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

If your health history is not completed during at your pre-registration appointment, please mail, drop off, or fax the completed form prior to your appointment. If you cannot return this form prior to your appointment, you must arrive 30 minutes early so you can complete the form. Thank you for your cooperation!