# Medical History Form

Name: ________________________________ Age: _________ Height: _________ Weight: ____________

Pharmacy Name: _________________________ Location: __________________ Phone: ________________

**List Any Allergies to Medications/Food:** ☐ **No Known Drug Allergies**

☐ Aspirin ☐ Sulfa ☐ Penicillin ☐ NSAIDS ☐ Codeine ☐ Other: _______________

________________________________________________________________________________________

**List Current Medications Including Over the Counter Medications** ☐ **No Current Medications**

Name Strength/Dosage Directions/Frequency

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

**Past Medical History: Do you have any medical problems listed below?** ☐ **None**

☐ Anemia ☐ Constipation ☐ Goiter ☐ Osteoporosis
☐ Angina/Chest Pain ☐ Coronary Artery Disease ☐ Heart Attack ☐ Rash
☐ Arthritis/Joint Pain ☐ Depression/Anxiety ☐ Hepatitis ☐ Seizure Disorder
☐ Asthma ☐ Diabetes ☐ High Blood Pressure ☐ Stomach Issues/Acid Reflux
☐ Blood Clots ☐ Diarrhea ☐ High Cholesterol ☐ Stroke, CVA/TIA
☐ Cancer: __________ ☐ Diverticulitis/Diverticulosis ☐ Kidney Disease ☐ Thyroid Disease
☐ Constipation ☐ Enlarged Prostate ☐ Kidney Stones
☐ COPD (Emphysema) ☐ Gallbladder Disease ☐ Migraine/Headaches

**Past Surgical History: Have you ever had any surgeries? What year did they occur?** ☐ **None**

☐ Appendix Removal ☐ Fibroid Removal ☐ Hip Replacement – RIGHT/LEFT
☐ Back Surgery ☐ Gallbladder Removal ☐ Knee Replacement – RIGHT/LEFT
☐ Carpal Tunnel Release ☐ Heart Bypass ☐ Pacemaker
☐ Cataract Surgery ☐ Heart Stent ☐ Prostate Removal/Seeds
☐ Colon Resection ☐ Hernia Repair ☐ Tonsil/Adenoid Removal
☐ Other: _______________________________________________

**Female Only:**

Still menstruating? YES NO ☐ Date of Last Period: ______________
☐ Menopause/Menopausal Symptoms ☐ C-Section ☐ Hysterectomy
☐ Breast Biopsy/Surgery ☐ Breast Augmentation
☐ Are you Pregnant? ☐ Are you nursing?
☐ Date of Last Mammogram: ____________________ ☐ Date of Last PAP: ________________

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**Social History**

☐ Single ☐ Married ☐ Divorced ☐ Widowed
☐ Do you use tobacco? YES NO
☐ Do you consume Alcohol? YES NO
-How often? Daily Weekly Monthly Rarely
-How many? 1-2 drinks 3-4 drinks 4-5 drinks 6+ drinks
☐ Use Marijuana? YES NO

☐ Do you have children? How Many? _________________________
☐ Occupation? _____________________________________________
☐ Retired? What was your past profession? ____________________

**Family Medical History** ☐ **Adopted/Unknown**

| | **If Living** Age | Medical Conditions | **If Deceased:** Age at Death | Cause of Death/Medical Condition |
|---|---|---|---|---|
| Father: | | | | |
| Mother: | | | | |
| Brother(s): | | | | |
| Sister(s): | | | | |

**Preventive Care/Services:** *Please provide approximate dates of your last screening services:*

☐ PSA (Prostate) __________________________________ (Male Only)
☐ Cholesterol ____________________________________
☐ Colonoscopy____________________________________
☐ Eye Exam ______________________________________

**Vaccines (What date did you receive them?)** ☐ **NONE**
☐ FLU ______________________________ ☐ Pneumonia ________________________________
☐ Shingles _____________________________ ☐ Tetanus ___________________________________

**Patient Signature: ____________________________________________________ Date: ________________________**