MEDICAL HISTORY FORM

Patient: ______________________________________**Primary Care Physician**: __________________________

Pharmacy: ___________________________ **Pharmacy City**: __________________________________

Past Medical History: Please check all that apply to you

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV			Colitis, ulcerative			Hepatitis			Pulmonary embolism		
Anemia			Congestive heart Failure			High blood pressure			Reflux/heartburn		
Aneurysm			COPD/Emphysema			High Cholesterol			Renal failure, chronic		
Angina			Crohn's disease			Irregular Heartbeat			Sarcoidosis		
Arthritis, Rheumatoid			Dementia			Irritable Bowel			Seizures		
Asthma			Diabetes			Liver disease			Stroke		
Bleeding Disorder			Down's Syndrome			Lyme			Thyroid condition		
Blindness			Deep Vein Thrombosis			Lupus			TIA (stroke)		
Brain Tumor			Esophageal stenosis/ stricture			Multiple Sclerosis			Ulcers-please circle Skin or GI		
Bronchitis, Chronic			Fibromyalgia			Osteoarthritis			Vascular disease, peripheral		
Cancer *list info below			Glaucoma			Pituitary condition			Other:		
Cirrhosis			Heart attack			Prostate condition			Other:		

CANCER: Where?____

Past Surgeries:

____

____

Medications: Prescription and Over the counter that you are currently taking:

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

Please list any medications you are <u>allergic to</u> and what kind of reaction you have:

____

____

Latex Allergy: ____ Yes ____ No Reaction: ______________________________

Could you be pregnant: ____ Yes ____ No

FAMILY HISTORY:

Bleeding disorders that run in family?	Yes	No	Who? ____________________
Head and Neck cancer? (Please circle which)	Yes	No	Who? ____________________
Thyroid cancer?	Yes	No	Who? ____________________
Diabetes?	Yes	No	Who? ____________________

SOCIAL HISTORY:

Tobacco Current/Past Year quit: _______ ____ Packs per day How many years? ____

Other tobacco use Current Yes No Past Yes No

Alcohol Current Yes No #____ per day Past Yes No

Use of recreational drugs Current Yes No Past Yes No

PATIENT'S SIGNATURE: ____ **DATE**: _______________

PLEASE COMPLETE OTHER SIDE: **CLINICAL STAFF INITIALS:**

____

Patient Name: ____ Date of Birth:_____________________

REVIEW OF SYSTEMS

Please circle any symptoms that apply

General
Weight loss, weight gain, generalized weakness

Eyes
Double vision, change in vision, excessive tearing, dry eye

Cardiovascular
Chest pain, rapid heart rate, passing out

Respiratory
Shortness of breath, wheezing, cough

Gastrointestinal
Nausea, vomiting, diarrhea

Skin
Rash, itching, color changes

Neurologic
Hearing loss, speech difficulties, seizures, incoordination

Musculoskeletal
Joint pain, joint swelling, muscle pain

Endocrine
Cold intolerance, heat intolerance

Heme-Lymph
Easy bleeding, easy bruising, lymph node enlargement

Allergic-Immunologic
Hives, frequent infections, eczema

MEANINGFUL USE QUESTIONS

Ethnicity
Not Hispanic / Latino_______ Hispanic / Latino_______

Race
White ______ American Indian / Alaska Native ______ Asian ________ Black / African American ______

Native Hawaiian / Pacific Islander ______ Other Race ______ Declined ______

PATIENT/GUARDIAN SIGNATURE:_____________________________________ DATE:__________________

CLINICAL STAFF INITIALS: __________________