PATIENT HISTORY FORM

Name:	Date:	Age:
What is the reason for your visit today?		
Family Physician and Date last seen:		
Whom may we thank for referring you?		
Have you sought treatment for this problem in the past? Yes ( ) No ( )		
Pharmacy name and City:		

Personal and Family History S=Self F=Family Member		**Circle all that apply**
S F Heart Trouble	S F Diabetes (Insulin /Non Insulin)	S F Arthritis
S F Heart Murmur	S F Liver Disease	S F Joint Replacement
S F Heart Attack	S F Hepatitis / Jaundice	S F Back Problems
S F High Blood Pressure	S F Thyroid Disease	S F Foot Injuries
S F Stroke	S F Stomach Problems	S F Rheumatic Fever
S F Circulation Problems	S F Gastric Reflex	S F Gout
S F Vascular Surgery	S F Bladder / Kidney Problems	S F HIV / AIDS
S F Bleeding Problems	S F Uterine Problems	S F Neuropathy / Burning Feet
S F Depression	S F Prostate Problems	S F Foot Ulcers
S F Anxiety	S F Asthma / Bronchitis	S F Cancer
S F Other	S F Sleep Apnea	S Currently Pregnant

Current Medications - Please list all prescriptions, over-the-counter medications, and vitamins					
Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency

Allergies - Mark all that apply				
___ Codeine	___ Penicillin	___ Aspirin	___ Iodine	___ Latex
___ Tapes/Adhesives	___ Sulfa	___ Demerol	___ Metals	___ Morphine
___ Lortab	___ Cephalexin	___ Other (please list)		
___ No known drug allergies				

Surgical History			
Type of Surgery	Year	Type of Surgery	Year
1.		4.	
2.		5.	
3.		6.	

Social History Circle all that apply			
Yes No Tobacco	Yes No Alcohol	Yes No Drug abuse/addiction	Yes No Blood borne disease

The above information is true to the best of my knowledge. Signature: _____ Date:_____