PATIENT MEDICAL HISTORY FORM

Preferred Pharmacy:

Primary Care Physician:

Allergies:

□ None/No Known Drug Allergies □ Adhesive Tape □ Anesthesia □ Aspirin □ Codeine □ Dairy Products
□ Iodine/Shellfish/Contrast dye □ Latex □ Morphine □ Penicllin □ Sulfa Drugs □ Wheat
□ Others (please specify):

Family History

	Mother	Father	Sibling (brother/sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

Social History

Occupation:_____ □ Retired □ Disabled (reason) _____

Do you drink alcohol? □ Yes □ No If YES, how often? □ Daily □ Weekly □ Infrequently

Do you use tobacco? □ Yes □ No □ Quit, past smoker If YES, □ Smoke (____ packs per day) □ Chew

Surgical History (Please list any hospitalizations, surgeries, fractures, or major illnesses you have had)

Type of Surgery	Year or Date	Doctor	Location

Medical History (Please check if you <u>ever</u> had any of the following):

□ NONE of the problem listed
□ Anemia
□ Arthritis
□ Asthma
□ Atrial Fibrillation
□ Bleeding Disorders
□ BPH
□ Coronary Artery Disease
□ Cancer _____
□ Cardiac Arrest
□ Celiac Disease
□ Chest Pain
□ Congestive heart failure
□ Chronic fatigue syndrome
□ Deep Venous Thrombosis
□ Depression
□ Diabetes (I or II)
□ Drug/Alcohol Abuse
□ Fibromyalgia
□ GERD
□ Heart disease
□ High Cholesterol
□ Hyperinsulinemia
□ Hyperlipidemia
□ Hypertension
□ HYPERthyroidism
□ HYPOthyroidism
□ Infection problems
□ Insomnia
□ Irritable Bowel Syndrome
□ Kidney problems
□ Migraines/Headaches
□ Neuropathy
□ Onychomycosis
□ Organ Injury
□ Osteoporosis
□ Pulmonary Embolism
□ Seizure Disorders
□ Shortness of Breath
□ Sinus conditions
□ Strokes
□ Tremors

Medications (Please list any medications you are taking, including over-the-counter medications):