MEDICAL HISTORY

PATIENT NAME_________________________________ Referred by:_________________________
EMAIL ADDRESS ________________________________ D.O.B ______________________________
PRIMARY CARE PHYSICAN _______________________ TODAY'S DATE ______________________
ALLERGIES TO MEDICATION(S) ____

MEDICAL HISTORY (Please check if you have a history of any of the following conditions)

- ☐ Kidney Disease
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Stroke
- ☐ Pneumonia
- ☐ Arthritis
- ☐ Reflux
- ☐ Cancer (pls. specify)
- ☐ Skin Cancer
- ☐ Asthma
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Speech/Hearing Problems
- ☐ Tuberculosis
- ☐ Blood Transfusions
- ☐ Emphysema/COPD
- ☐ Back Problems
- ☐ Ulcer Problems
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Bleeding/Clotting Problems
- ☐ Jaundice/Hepatitis

OTHER____

PREVIOUS SURGERIES (Please check if you've had any of the following surgeries)

- ☐ Ear
- ☐ Eye
- ☐ Nose
- ☐ Breast
- ☐ Heart
- ☐ Gallbladder
- ☐ Hemorrhoid
- ☐ Back/Neck Surgery
- ☐ Joints (Hip/Knee)
- ☐ C-Section
- ☐ Tonsil/Adenoid Surgery
- ☐ Appendectomy
- ☐ Hysterectomy

OTHER ____

FAMILY HISTORY (Please check if you have a family history of any of the following)

- ☐ Heart Disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer (please specify)
- ☐ Stroke
- ☐ Breast Cancer

OTHER ____

MEDICATIONS

	YES	NO	CURRENT MEDICATIONS & DOSAGE
Do you take aspirin	☐	☐	________________________
Do you take blood thinning medications	☐	☐	________________________
Do you take estrogen/progesterone or birth control pills	☐	☐	________________________
Do you currently smoke	☐	☐	________________________
Have you ever smoked	☐	☐	________________________
If yes, how many packs daily________			________________________
How many years__________			________________________
Do you consume alcohol?	☐	☐	________________________
If yes, how much __________			________________________
Do you or have you ever used illegal drugs?	☐	☐	________________________
If yes, what type__________________			________________________

VITAL SIGNS

DATE	AGE	BP	PR	RR	Ht	Wt	BMI

PHARMACY

NAME: ________________________________ ADDRESS: ______________________________
PHONE NUMBER:____________________________