Medical History Form

Patient's Name: _____ Today's Date: _____
Social Security Number: _____ Date Of Birth: _____

Which of the following conditions are you currently being treated or have been treated in the past:

__ Heart Disease
__Eye Disorder/ Glaucoma
__High Blood Pressure
__Low Blood Pressure
__Heartburn (reflux)
__Anemia or blood problems
__Thyroid problems
__Tonsillitis
__Diabetes
__High Cholesterol
__Stroke
__Neurological Problems
__Psychiatric Care
__Kidney/ Bladder Problems
__Arthritis
__Shortness of Breath
__Asthma
__Lung/ Cough Problems
__Sinus Problems
__Seasonal Allergies
__Ear Problems
__Cancer _____
__Seizures
__Headaches/Migraines
__Depression/Anxiety
__Liver/Hepatitis Problems
__Ulcers/Colitis

Please describe any current or past medical treatment not listed above:
_____
_____.
Please List your past surgeries: _____.

What are you allergic to?_____.
What medications are you on?_____.

Social and Preventive History:
Do you smoke or chew tobacco?_____ If not, have you in the past?_____
How many packs per day? _____

Do you drink alcohol, beer, or wine? _____ If not, have you in the past? _____
How many drinks per week? _____

Do you currently drink coffee and/or tea? _____
If yes, how many cups per day? _____
Do you exercise daily/weekly? _____
Do you use seatbelts while driving? _____

Has any members of your family (children and parents too) had any of the following illnesses?

Anemia/ blood disease? _____If yes, who? _____
Cancer? _____ If yes, who and where? _____
Diabetes? _____ If yes, who? _____
Glaucoma? _____ If yes, who? _____
Heart Disease? _____ If yes, who? _____

High blood pressure? _____ If yes, who? _____
HIV Disease/ AIDS? _____ If yes, who? _____
Mental Illness/ Depression? _____ If yes, who? _____
Stroke? _____ If yes, who? _____
Other? _____ If yes, who? _____

FEMALES: Gynecological history
How many times have you been pregnant? _____
How many children do you have?_____
If the first two numbers are not the same, please explain _____
_____.
Date of last pap _____
Have you had an abnormal pap smear? _____ If yes, reason? _____
Have you had a sexually transmitted disease? _____ If yes, what? _____
Date of last mammogram? _____ Results? _____
Have you had a breast biopsy? _____ If yes, results? _____

How would you like your prescriptions? Circle 1 or 2.

1. Transmitted to your pharmacy
   Pharmacy Name _____
   Street located: _____
   Phone Number: _____
2. Paper prescription

By signing below, I hereby certify that to the best of my knowledge, all the information I have furnished on this form is complete, true and accurate.

Patient/ Legal Guardian Signature _____
Date: _____