

GENERAL INFORMATION AND MEDICAL HISTORY

(To be completed by patient) Date: _____

Patient Name: _____ Date of Birth: _____

Pharmacy/Location: _____

MEDICATIONS – you are presently taking (both prescription drugs and over the counter):

SOCIAL HISTORY:

- Smoke , How much? _____
 Drink alcoholic beverages, How often? _____
 Caffeine Usage, How often? _____
 Drug Use _____

Marital Status: Single Married Divorced Widowed

Children: How many? _____

Occupation: _____

Employment PT FT Unemployed Retired Disabled Student

PAST MEDICAL HISTORY:

PLEASE COMPLETE THE FOLLOWING SECTION

	YES	NO		YES	NO
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	<input type="checkbox"/>
Chronic diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric illness	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Raynaud's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Drug addiction	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
			Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
			Ulcer	<input type="checkbox"/>	<input type="checkbox"/>

SURGICAL HISTORY – List all operations and dates: _____

FAMILY HISTORY:

Please complete the following section. By every "Yes" answer please indicate which family member.

	Living	Deceased	Age	Reason
Father	[]	[]	_____	_____
Mother	[]	[]	_____	_____
Sibling	[]	[]	_____	_____

	YES	NO	Please Describe
Alcoholism	[]	[]	_____
Allergies	[]	[]	_____
Alzheimer's	[]	[]	_____
Birth defects	[]	[]	_____
Cancer, _____	[]	[]	_____
Congenital illness	[]	[]	_____
Depression / Suicide	[]	[]	_____
Diabetes	[]	[]	_____
Heart disease	[]	[]	_____
High blood pressure	[]	[]	_____
Kidney Disease	[]	[]	_____
Liver Disease	[]	[]	_____
Lung Cancer	[]	[]	_____
Lupus	[]	[]	_____
Mental Illness	[]	[]	_____
Migraine Headaches	[]	[]	_____
Rheumatoid arthritis	[]	[]	_____
Seizure Disorder	[]	[]	_____
Stroke	[]	[]	_____
Thyroid problems	[]	[]	_____
Tuberculosis	[]	[]	_____
Ulcer	[]	[]	_____
Other	[]	[]	_____

DRUG ALLERGIES – name and symptoms: _____

ADVANCE DIRECTIVE [] Yes [] No

[] Living Will [] Health Care Proxy [] Power of Attorney for Health Care
[] Other _____