Account (office use):_____ **PATIENT MEDICAL HISTORY FORM** Date:_____ Int_____

Name: _____ DOB: _____ Age: _____ Height: _____ Weight: _____

Are you Right____ or Left____ Handed? Date of Injury or onset of problem: _____ BP_____ P_____

If an injury, where did it take place? Home__ School__ Work__ Other__ **PHARMACY** (Name/City) _____

CURRENT or CHIEF PROBLEM

Area of body to be examined: _____ Which side? Left___ Right___

What is your pain level today (circle one): 1 2 3 4 5 6 7 8 9 10 Did this injury occur during a fall? Y N

How does it affect you, i.e. Swelling Bruising Numbness Weakness ECT? _____

When does it affect you most and how long does it last? _____

Type of pain: SHARP____ DULL____ THROBBING____ STABBING____ BURNING____ RADIATING____

INFECTION HISTORY

*Circle if you currently have or have had:

Hepatitis	HIV/AIDS	MRSA	Bone/Joint Infection	Surgical Site Infection
Yes No	Yes No	Yes No	Yes No	Yes No

Have you had the following vaccinations?: Tetanus/T-Dap ___ Flu ___ Hepatitis B ___ Pneumonia ___

CHRONIC ILLNESSES

*Circle if you currently have or have had:

Diabetes Hypertension/HBP Heart Disease/MI/Cardiac Stents Heart Arrhythmia	CABG/Heart Bypass Pacemaker/Defibrillator Emphysema/COPD Asthma/Bronchitis	Pulmonary Embolus Blood Clots/DVT Sleep Apnea (CPAP) Anemia	Blood Transfusion Cancer Reflux/Ulcer Seizures
	Other:		

REVIEW OF SYSTEMS

* Please circle all symptoms which are significantly affecting you today:

MUSCULOSKELETAL
Joint Pain
Joint Swelling
Joint Stiffness
Muscle Pain
Instability

NEUROLOGIC
Numbness/ Tingling
Dizziness
Nervousness
Anxiety
Seizures
Tremors
Balance Disturbances

RESPIRATORY
Shortness of Breath
Wheezing
Cough

GASTROINTESTINAL
Heartburn
Nausea
Vomiting
Constipation
Diarrhea

SKIN
Skin Changes
Poor Healing
Rash
Itching

EARS, NOSE & THROAT
Corrective Lenses
Blurred/Double Vision
Eye Pain
Headache
Difficulty Swallowing
Nose Bleeds
Earaches

HEMATOLOGIC
Easy Bleeding
Easy Bruising

ENDOCRINE
Excessive Thirst
Excessive Urination
Heat or Cold Intolerance

RENAL
Difficult/Painful Urination
Frequency
Urgency
Incontinence

GENERAL
Unexpected Weight Loss
Unexpected Weight Gain
Fever
Chills
Fatigue

CARDIOVASCULAR
Chest Pain
Palpitations
Fainting

NOTES: _____

_____

OVER →

PREVIOUS OPERATIONS *Please list:

Type	Year	Reason
1.		
2.		
3.		
4.		

Have you ever had anesthesia complications? No Yes
Please describe if answered Yes: _____
_____

Do you have a pain management contract? No Yes With which doctor or hospital? _____

I authorize the following people to pick up my prescriptions:_____

Are you taking any Blood Thinning medications, i.e. Coumadin____ Warfarin____ Plavix____ Xarelto____ Effient____ Pradaxa____ Eliquis____ Aspirin____ Other: _____

CURRENT MEDICATIONS *if you are providing your own list, circle here: MY MED LIST

Medication / Vitamin / Herbal Supplement	Dose	How often?	What condition is the prescription for?
1.			
2.			
3.			
4.			

ALLERGIES: Medications, Solutions or Metal

Medication, Solution or Metal Name	Allergic Reaction
1.	
2.	
3.	
4.	

FAMILY HISTORY

PLEASE INDICATE WITH RELATIONSHIP (i.e. father): Do you know of any blood relatives who have or have had any of the following?

Cancer	Diabetes	Epilepsy
Heart Disease	High Blood Pressure	Psoriasis
Congenital Problems	Obesity	Asthma
Alcoholism	TB	Thyroid Problems
Rheumatic Fever	Rheumatoid Arthritis	Stroke
Other:		

SOCIAL HISTORY

Tobacco Use?
Snuff No___ Yes___
E-Cigarettes No___ Yes___
Cigarettes: _____ packs a day
None___ Quit date _____

Drug Use?
Meth No___ Yes___
Cocaine No___ Yes___
Marijuana No___ Yes___
IV Drugs No___ Yes___

Alcohol Use?
Do you drink No___ Yes___
Drinks per week_____

Do you have an Advance "Directive"?
No___ Yes___

Employment
Employer: _____ Occupation: _____ Unemployed Disabled Retired