Name ____ Age___________ Date_______________

Primary Care Physician___________________________ Referring Physician______________________________

Reason for visit: ____

MEDICAL INFORMATION:

Past Medical History: (List any past or current medical problems)

____

Surgical History (List any past or current procedures and operations)

____

Medications (Including dietary supplements, non-prescription and herbal products)

____ ____

____ ____

____ ____

____ ____

Allergies ☐ None

____ Reaction: ☐ Mild ☐ Moderate ☐ Severe

____ Reaction: ☐Mild ☐ Moderate ☐ Severe

Social History

Current Occupation_________________________________ Employer____________________________________

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Are you a: ☐ Current Smoker ☐ Former Smoker ☐Never Smoked

***If smoker or former smoker: Packs per day____________ How many years? _____________

Do you consume alcohol? ☐ Yes ☐ No Number of drinks per week _______________

Do you use recreational drugs? ☐ Yes ☐ No

Family Medical History (please explain if any of these conditions have affected a family member)

☐ **Cancer** : ☐Father ☐Mother ☐Son ☐Daughter ☐Brother ☐Sister ☐ Aunt ☐Uncle
☐Maternal Grandfather ☐Maternal Grandmother ☐ Paternal Grandfather ☐Paternal Grandmother

☐ **Diabetes**: ☐Father ☐Mother ☐Son ☐Daughter ☐Brother ☐Sister ☐ Aunt ☐Uncle
☐Maternal Grandfather ☐Maternal Grandmother ☐ Paternal Grandfather ☐Paternal Grandmother

☐ **High Cholesterol**: ☐Father ☐Mother ☐Son ☐Daughter ☐Brother ☐Sister ☐ Aunt ☐Uncle
☐Maternal Grandfather ☐Maternal Grandmother ☐ Paternal Grandfather ☐Paternal Grandmother

☐ **High Blood Pressure**: ☐Father ☐Mother ☐Son ☐Daughter ☐Brother ☐Sister ☐ Aunt ☐Uncle
☐Maternal Grandfather ☐Maternal Grandmother ☐ Paternal Grandfather ☐Paternal Grandmother

☐ **Gallbladder problems**: ☐Father ☐Mother ☐Son ☐Daughter ☐Brother ☐Sister ☐ Aunt ☐Uncle
☐Maternal Grandfather ☐Maternal Grandmother ☐ Paternal Grandfather ☐Paternal Grandmother

Do you have now, or have you been diagnosed as having any of the following:

☐ Fever
☐ Weight loss
☐ Weakness/Fatigue
☐ Headaches
☐ Vision problems
☐ Hearing difficulties
☐ Enlarged glands/Lymph nodes
☐ Chest pain
☐ Heart murmurs
☐ Heart palpitations
☐ Irregular or rapid heart beat
☐ Heart attack
☐ Heart failure
☐ Shortness of breath
☐ Asthma
☐ Vomiting of blood
☐ Blood in stool
☐ Dark black stool
☐ Abdominal pain
☐ Chronic nausea and vomiting
☐ Constipation
☐ Diarrhea
☐ Hepatitis
☐ Frequent heartburn or reflux
☐ Stomach or intestinal ulcer
☐ Hernia
☐ Arthritis
☐ Swelling of feet/legs
☐ AIDS or HIV
☐ Anemia
☐ Bleeding disorder
☐ Deep Vein Thrombosis (DVT)
☐ Pulmonary Emboli (PE)
☐ Cancer or tumor
☐ Thyroid disease
☐ Stroke
☐ Seizures
☐ Mood disturbance/Depression/Anxiet

Additional information if needed:

____

Preferred Pharmacy: _______________________________ Location: ________________________

Pharmacy Phone number: ___________________________

Print Name: ______________________________ Relationship if not patient: ____________________

Signature: ____ Date:___________________