# MEDICAL HISTORY

Patient Name: _____ Date of Birth ___ / ____ / _____

☐ Medical History Provided in Hospital H&P or Discharge Summary

Pharmacy Name: _____ Pharm Location: _____ Phar Phone: _____

Preferred Lab: _____ Lab Phone: _____

What problems are you here for today?

_____

_____

Please list **all medications, dosage & frequency**. Include prescriptions, over-the-counter medications & herbal therapies.

☐ SEE ATTACHED MEDICATION LIST

_____

_____

_____

Are you **allergic to any medications**? If so, please list and explain type of reaction.

_____

List all Hospitalizations and operations including the year:

_____

_____

Do you smoke? If yes, number of packs per day? _____ YES / NO
Do you drink any alcoholic beverages? If yes, # per day? _____ YES / NO
Have you recently traveled outside of the country? YES / NO
Have you or do you plan on having the flu immunization? YES / NO
Are you Pregnant or nursing? YES / NO

Please check (√ ) if you have or have had problems with any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Blood transfusion | | Chronic fever | | Cough, Persistent | |
| HIV / AIDS | | Venereal Disease | | Congenital Heart lesions | |
| Hepatitis C | | Skin Rash | | Cortisone Treatments | |
| Tuberculosis | | Anemia | | Swelling of feet or ankles | |
| Scarlet fever | | Hemophlia | | Chemotheraphy or Radiation Treatment | |
| Rheumatic fever | | Cough up blood | | | |

To the best of your knowledge, have YOU or ANY members of your family ever had problems with the following:
Please explain all "YES" answers. Please note this is not a complete list & additional space is available to expand upon this list.

| | MYSELF | FAMILY MEMBER |
|---|---|---|
| Cancer (describe type) | | |
| Hypertension (high blood pressure) | | |
| Heart Diseases (heart attack, heart murmur) | | |
| Diabetes | | |
| Neurological (stroke, migraines, weakness, spinal cord, seizures) | | |
| Allergy / Immune Problems (HIV, Immune suppression) | | |
| Thyroid Problems | | |
| Respiratory Diseases (Tuberculosis, Emphysema) | | |
| Genital / Urine / Liver Problems (Hepatitis, cirrhosis) | | |
| Kidney | | |
| Stomach Problems (ulcers, reflux, hernia, bleeding) | | |
| Mental diseases (anxiety, depression, etc.) | | |
| Drug or alcohol addiction | | |
| Bleeding diseases (sickle cell, anemia) | | |

Other or Explanation:

_____

_____

_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever has a change in health.

Printed Name / Signature of Patient **OR** Signature of Parent, Guardian or Personal Representative Date

_____ _____

Revised 11/14/13