PATIENT HEALTH HISTORY

Patient Name: ________________________ DOB: __________________ Date: _________________

Reason for Visit today: ___________________________ When did symptoms/injury begin? ____________

When did you receive your last Tetanus?

What is the Name and Location of the Pharmacy you will be using today? __________________________
Pharmacy Address ____

Please list all medications you are currently taking including any over-the-counter meds.

Medication	Dosage	Reason

Please indicate any drug allergies.

Please indicate other allergy types (Seasonal/Food) – ***If yes, would you like to be tested? YES___ NO____***

Please indicate any health conditions for which you are currently being treated or have ever been treated.

Condition	YES	NO	Condition	YES	NO
High Blood Pressure			Liver Disease		
Heart Attack			Kidney Disease		
Diabetes			Cancer		
Stroke			Tuberculosis		
Asthma			Stomach Ulcers		

Please list any surgeries, hospitalizations and/or serious injuries.

Reason/Type	Date	Reason/Type	Date

Please indicate any Family related medical condition (mother, father, brother or sister) whom have had or currently have the following:

Heart Attack	YES	NO	At what age?	Who?
Stroke	YES	NO	At what age?	Who?
Cancer	YES	NO	At what age?	Who?

Any chance you are pregnant? Yes ___ No__ If no, what is the date of last menstrual cycle? ________
Are you a smoker? Yes ___ No___ If yes, how many packs a day?
Do you drink alcohol? Daily ___ Socially___ Never___