HEALTH HISTORY | Favorite Pharmacy:________________
E-mail Address:____________________

Please print and use a black pen to fill out this form. Date:_____________

Last Name:___________ First Name:___________ MI:____ Nickname:_________________

Spouse Name:__________________ Birth date:__________________ Age:_________

Medication Allergies

Please list any medications you cannot take and describe what reaction you have:

Immunization

Adults: What is the date of your last tetanus shot?_______ Pneumonia shot?________ Flu shot?______
Hepatitis A shot?______ Hepatitis B shot?_______ Shingles shot?________ H1N1?________

Children (under the age of 16): Please attach your immunization record.

Family History: **Please specify if relation is Maternal(M) or Paternal(P) Grandparent**

O Cancer

Type of Cancer — Relation (parents, siblings, Grandparents, aunts/uncles)

O Breast ____________________________
O Colon/Rectal ____________________________
O Kidney (Renal Cell) ______________________
O Leukemia ____________________________
O Lung ____________________________
O Non-Hodgkins Lymphoma _________________
O Ovarian __________________________
O Pancreatic ____________________________
O Prostate _____________________________
O Skin (basal cell/squamous) _____________
O Skin (melanoma) ________________________
O Uterus ___________________________
O Other _________________________________

O Mental Illness/Alcoholism (please specify)
Relation (parents, grandparents, siblings, aunts/uncles)
Age of Onset
____
____

O Heart Attack/Heart Disease (please specify)
Relation (parents, grandparents, siblings, aunts/uncles)
Age when relative had first heart attack
____
____

O High Blood Pressure
Relation (parents, siblings, grandparents, aunts/uncles)
____

O Stroke
Relation (parents, grandparents, Siblings, aunts/uncles)
Age of relative had first stroke
____
____

O Diabetes
Relation (parents, grandparents, siblings, aunts/uncles)
Age of Onset
____
____

O High Cholesterol
Relation (parents, grandparents, siblings, aunts/uncles)
____
____

O Osteoporosis
Relation (parents, grandparents, siblings, aunts/uncles)
____
____

O Depression **O Bipolar Disorder**
Relation (parents, grandparents, siblings, aunts/uncles)
____

O Other Diseases (please specify)
Diagnosis and relation
____
____

PERSONAL MEDICAL HISTORY

Last name____________________ First name____________________ Date__________

Please check any of YOUR diagnosed chronic conditions.

O Acne
O Adrenal problems
O AIDS/HIV
O Alcoholism
O Allergies
O Anemia
O Anxiety
O Arthritis
O Asthma
O Back pain
O Bleeding disorders
O Breast lump
O Cancer
Type____________
O Cataracts
O Celiac disease
O Cold sores
O Crohn's disease
O Dementia
O Depression
O Diabetes
O Diverticulosis
O Eating disorder
O Emphysema
O Endometriosis
O Epilepsy
O Fibromyalgia
O Glaucoma
O Goiter
O Gout
O Hearing loss
O Heart burn/reflux
O Heart disease
O Hernia
O Herpes
O High blood pressure
O High cholesterol
O HIV positive
O Incontinence
O Insomnia
O Irritable bowel syndrome
O Hepatitis
O Kidney disease
O Kidney stones
O Liver disease
O Meniere's disease
O Menopause
O Migraines
O Multiple sclerosis
O Pacemaker
O Polycystic ovary syndrome
O Prostate problems
O Psychiatric care
O Seizure disorder
O Sleep apnea
O Stroke
O Thyroid (high)
O Thyroid (low)
O Thyroid Cancer
O Tobacco Use
O Tuberculosis
O Ulcerative Colitis
O Ulcers
O Uterine Fibroids
O Other
____

____

Surgeries (please list any surgeries you have had)

Name of surgery	Year performed
__________________	_________________
__________________	_________________

Last eye exam date _____/_____/______

Diagnostic Testing	Date	Results
PSA Blood test(male)	______	_________________
EKG	________	_________________
Chest x-ray	________	_________________
PAP	________	_________________
Mammogram	________	_________________
Colonoscopy	________	_________________
Colposcopy	________	_________________
Bone density	________	_________________
Other:	________	_________________

Pregnancy History (women only)

O I have never been pregnant.
O I have been pregnant a TOTAL of _____ times.
O I have had a total of ______ vaginal deliveries.
O I have had a total of ______ caesarian sections.
O I have had a total of ______ abortions.
O I have had a total of _____ miscarriages.

Social History

Exercise (please check one)
O I don't exercise.
O I rarely exercise.
O I exercise 1-2 times a week.
O I exercise 3 + times a week.

Smoking (please check one)
O I have never smoked.
O I used to smoke cigarettes but quit in __________ (year).
O I still smoke cigarettes. I have smoked and average of _______ packs per day for _______ years.
Exposed to 2nd hand smoke Y or N

Alcohol (please check one)
O I do not drink alcohol.
O I drink an average of ______ drinks a week.

Street drugs (please check one)
O I do not use drugs.
O I use/ have used the the following____________

Caffeine (please check one)
O I do not drink beverages w/ caffeine.
O I drink an average of _____ cups of coffee per day.
O I drink an average of ______ cups/glasses of tea per day.
O I drink an average of ______ cans of soda per day.
O I drink an average of _______ energy drinks per day.

Miscellaneous
I have a living will Y or N
I have served in the military. Y or N
I am an organ donor Y or N
I wear seatbelts Y or N

Travel
Have you traveled outside the U.S. recently? Y or N
If yes, which country did you visit?
____

Medications please list all medications you are taking

Prescription Medications

Medication name	dosage(#mg)	how much

Nonprescription Medications

Medication name	dosage (#mg)	how much