Medical History Form

Appointment Date _____

Full Name _____ **Male** ☐ **Female**☐ **Date of Birth** _____

Pharmacy Preference **(include location)** _____

Name of Primary Care (Family) Physician _____ **Referred by** _____

CURRENT MEDICATIONS:

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)
☐ **No** ☐ **Yes** **If yes, please list below and *include dosages*.**

Medication Name	Dosage	How often taken

MEDICATION ALLERGIES: **ARE YOU ALLERGIC TO ANY MEDICATIONS?** ☐ **No** ☐ **Yes** **If yes, please list below.**

Name of Medication	Type of Reaction

PAST HEALTH HISTORY:

Have you ever been *DIAGNOSED* with any of the following problems?

Cancer (type)_____ ☐ **No** ☐ **Yes** What year?_____

Ears:
Ear Infections `` ☐ **No** ☐ **Yes** What year?_____
Hearing Loss ☐ **No** ☐ **Yes** What year?_____
Meniere's disease ☐ **No** ☐ **Yes** What year?_____

Nose and Sinus:
Chronic Sinusitis ☐ **No** ☐ **Yes** What year?_____
Nasal Allergies ☐ **No** ☐ **Yes** What year?_____
Nasal Polyps ☐ **No** ☐ **Yes** What year?_____

Heart and Blood Vessels:
Irregular Heartbeat Requiring Treatment ☐ **No** ☐ **Yes** What year?_____
High / Elevated Cholesterol ☐ **No** ☐ **Yes** What year?_____
High Blood pressure ☐ **No** ☐ **Yes** What year?_____
Irregular Heartbeat Requiring Treatment ()

Lungs and Respiratory:
Asthma ☐ **No** ☐ **Yes** What year?_____
Tuberculosis ☐ **No** ☐ **Yes** What year?_____

Stomach and Digestive:
Hepatitis ☐ **No** ☐ **Yes** What year?_____
Reflux ☐ **No** ☐ **Yes** What year?_____
Stomach ulcer ☐ **No** ☐ **Yes** What year?_____

Genitourinary:
Are you pregnant? ☐ **No** ☐ **Yes**
Kidney Stones ☐ **No** ☐ **Yes** What year?_____
Renal failure ☐ **No** ☐ **Yes** What year?_____

Bones, Joints and Muscles:
Arthritis (Rheumatoid) ☐ **No** ☐ **Yes** What year?_____

Mental & Emotional:
Depression ☐ **No** ☐ **Yes** What year?_____
Anxiety ☐ **No** ☐ **Yes** What year?_____

Glands, Hormones, and Sugar Control:
Diabetes ☐ **No** ☐ **Yes** What year?_____
Low thyroid function ☐ **No** ☐ **Yes** What year?_____
High thyroid function ☐ **No** ☐ **Yes** What year?_____

Blood & Lymph Node problems:
Anemia ☐ **No** ☐ **Yes** What year?_____
Bleeding Disorder ☐ **No** ☐ **Yes** Type?_____

Allergies, Immune & Infectious Problems:
HIV ☐ **No** ☐ **Yes** What year?_____
Infectious mononucleosis ☐ **No** ☐ **Yes** What year?_____
Lupus ☐ **No** ☐ **Yes** What year?_____

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SURGERIES AND HOSPITALIZATIONS:

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ **No** ☐ **Yes**
If **yes**, please list what sort of problems. _____

Have you ever had surgery? ☐ **No** ☐ **Yes**
If **yes**, list any surgeries and when they were done. _____

Have you been hospitalized for a non-surgical problem before? ☐ **No** ☐ **Yes**
If **yes**, list hospitalizations, the reason for admission and the date. _____

FAMILY HISTORY:
(Circle if any applies)

Father:	Alive	or	Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Asthma	Allergy	Uknown
Mother:	Alive	or	Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Asthma	Allergy	Uknown
Child:	Alive	or	Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Asthma	Allergy	Uknown
Child:	Alive	or	Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Asthma	Allergy	Uknown
Child:	Alive	or	Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Asthma	Allergy	Uknown

SOCIAL HISTORY:
What is or was your occupation? _____ ☐ Check here if you are retired.

Have you ever used tobacco in any form? ☐ **No** ☐ **Yes**
If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _____		
Other: (list type) _____		

Do you consume alcohol? ☐ **No** ☐ **Yes**
If yes, please complete the following:

Type of Alcohol	How Much	How often

Are you exposed to second hand smoke? ☐ **No** ☐ **Yes**

Do you use drugs recreationally? ☐ **No** ☐ **Yes** **If yes, please list**_____

REVIEW OF SYSTEMS: **Mark yes or no and CHECK any of the following you have recently had**

General health problems ☐ **No** ☐ **Yes**
(☐fever, ☐sleeping problems, ☐unintentional weight loss)

Eye problems ☐ **No** ☐ **Yes**
(☐double vision, ☐itchy eyes)

Ear problems ☐ **No** ☐ **Yes**
(☐ear pain, ☐ear drainage, ☐hearing loss, ☐dizziness, ☐ringing)

Nose&Sinus problems ☐ **No** ☐ **Yes**
(☐chronic congestion, ☐ hay fever, ☐post nasal drainage)

Mouth & Throat problems ☐ **No** ☐ **Yes**
(☐change in voice, ☐snoring, ☐sore throat, ☐ulcers)

Heart or blood vessel problems ☐ **No** ☐ **Yes**
(☐blacking out or fainting, ☐bluish discoloration of lips or fingernails, ☐chest pain, ☐irregular heartbeat, ☐leg cramps, ☐swelling of ankles)

Lung or respiratory problems ☐ **No** ☐ **Yes**
(☐freq non-productive cough, ☐freq productive cough, ☐shortness of breath, ☐wheezing)

Stomach problems (Gastrointestinal) ☐**No** ☐ **Yes**
(☐abdominal pain, ☐diarrhea, ☐heartburn, ☐nausea, ☐vomiting)

Brain or Nervous system problems ☐ No ☐ Yes
(☐numbness, ☐seizures, ☐severe face pain, ☐weakness)

Problems with Glands, Hormones ☐No ☐ Yes
(☐feel cold all the time, ☐feel hot when others do not, ☐ increased appetite, ☐increased fatigue, ☐neck has enlarged, ☐unwanted weight change)

Problems with Blood or Lymph nodes ☐ **No** ☐ **Yes**
(☐bleeds excessively after injury, ☐bruises easily)

Problems with Allergies ☐ No ☐ Yes
(☐food intolerances, ☐hives, ☐ freq sneezing, ☐severe reaction to insect bites)