MEDICAL HISTORY FORM

Providing information about your personal and family medical history is one of the best ways to help you doctor learn a great deal about your health in a short period of time. The questions below are designed to help you remember and communicate important details of your past and current health history. Please complete as much of this worksheet as possible, answering as many of the questions as you can.

1. Patient Information

Name: ________________________________ Date of Birth: ____________________

Pharmacy Name: ______________________ Location / Phone: ____________________

2. Diagnostic Testing (Please check below if the patient had any of the following in the past 6 months)

- ☐ Complete Medical Exam
- ☐ Mammogram
- ☐ Breast Ultrasound
- ☐ Stress Test (Cardiac)
- ☐ Blood Work
- ☐ Carotid Ultrasound
- ☐ Colonoscopy
- ☐ Other Diagnostic Testing ____________________

3. Medications (List each with dosage and frequency)

☐ **See list** (If this box is checked be make sure you turn in a list of your current medications with your name, date of birth and today's date clearly printed on the list.

4. Allergies

5. Surgical History (List all past operations and the year)

6. Medical History (Check yes or no for each condition)

High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Kidney Failure	☐ Yes ☐ No

Cancer ☐ Yes ☐ No
If YES, what kind ______________________________

Immunizations: ☐ Pneumococcal ☐ Tetanus ☐ Influenza ☐ Other ____________________

List any other chronic (long term) medical conditions: ______________________________

7. Personal History

Tobacco ☐ Yes ☐ No How much? ____________ If former smoker, when did you quit? ___________
Alcohol ☐ Yes ☐ No How much? ____________ If former drinker, when did you quit? ____________
Caffeine ☐ Yes ☐ No Amt of coffee? _________ Amt. of tea? ___________ Amt. of soda? _______

Exercise: ☐ Regularly ☐ Occasionally ☐ Rarely
Recreational drug use: ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Other ____________________

8. Family History

Mother: ☐ Alive & Well ☐ Deceased Age Deceased _________
Cause of death: ______________________________

Father: ☐ Alive & Well ☐ Deceased Age Deceased _________
Cause of death: ______________________________

Brother/Sister: ☐ Alive & Well ☐ Deceased Age Deceased _________
Cause of death: ______________________________

Brother/Sister: ☐ Alive & Well ☐ Deceased Age Deceased _________
Cause of death: ______________________________

Brother/Sister: ☐ Alive & Well ☐ Deceased Age Deceased _________
Cause of death: ______________________________

Brother/Sister: ☐ Alive & Well ☐ Deceased Age Deceased _________
Cause of death: ______________________________

Are you adopted? ☐ Yes ☐ No

Have your **M**other, **F**ather, **S**isters or **B**rothers had any of the following?

	M	**F**	**S**	**B**
Alzheimers	☐	☐	☐	☐
Blood Disease	☐	☐	☐	☐
Coronary Artery Disease (Heart Attack)	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐
Other Cancer ________________	☐	☐	☐	☐
CVA (Stroke)	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Peripheral Vascular Disease	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐
Other: ________________________	☐	☐	☐	☐
______________________________	☐	☐	☐	☐

9. Physical Conditions & Disease (Check all that apply)

Weight
Present ________lbs
Usual __________ lbs
Any weight change in the past year ☐ Yes ☐ No

Skin
- ☐ Chronic or recurring skin condition
- ☐ Lump or growth on skin
- ☐ Change in color of skin
- ☐ ______________________________

Eyes
- ☐ Sudden loss of vision
- ☐ Decreased vision
- ☐ Double or blurred vision
- ☐ ______________________________

Genitourinary
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Bloody urination
- ☐ Discharge
- ☐ ______________________________

Respiratory
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Pneumonia
- ☐ ______________________________

Gastrointestinal
- ☐ Loss of appetite
- ☐ Nausea / Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in stool
- ☐ Blood in stool
- ☐ Diverticulosis
- ☐ Heart burn / Indigestion
- ☐ Hepatitis
- ☐ ___________________________

Neuropsychiatric
- ☐ Blackout spells
- ☐ Severe headaches
- ☐ Dizziness / Faintness
- ☐ More nervous than average
- ☐ Depression
- ☐ Insomnia
- ☐ ___________________________

Musculoskeletal
- ☐ Painful joints
- ☐ Sore muscles
- ☐ Chronic back pain
- ☐ ___________________________

Cardiac
- ☐ Chest pain
- ☐ Unable to lay flat
- ☐ Leg swelling
- ☐ Unusual heart beat
- ☐ ______________________

Vascular
- ☐ TIA/Ministroke
- ☐ Leg pain while walking
- ☐ Non-healing leg ulcer
- ☐ Spider Veins
- ☐ Varicose Veins
- ☐ _____________________

ENT
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Recurrent sore throat
- ☐ Persistent hoarseness
- ☐ Difficulty swallowing
- ☐ ______________________

Patient Name (print): ____

Patient Signature: ______________________________________ Date: ______________________