Account (office use):_____ **PATIENT MEDICAL HISTORY FORM** BP_____ P_____ Int_____

Name: _____ DOB: _____ Age: _____ Height: _____ Weight: _____

Are you Right____ or Left____ Handed? Date of Injury or onset of problem: _____

If an injury, where did it take place? Home__ School__ Work__ Other__ **PHARMACY** (Name/City) _____

CURRENT or CHIEF PROBLEM

Area of body to be examined: _____ Which side? Left___ Right___

How does it affect you, i.e. Swelling Bruising Numbness Weakness ECT? _____

When does it affect you most and how long does it last? _____

Type of pain: SHARP____ DULL____ THROBBING____ STABBING____ BURNING____ RADIATING____

INFECTION HISTORY

*Circle if you currently have or have had:

Hepatitis		HIV/AIDS		MRSA		Bone/Joint Infection		Surgical Site Infection	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

Have you had the following vaccinations?: Tetanus/T-Dap ___ Flu ___ Hepatitis B ___ Pneumonia ___

CHRONIC ILLNESSES

*Circle if you currently have or have had:

Diabetes Hypertension/HBP Heart Disease/MI/Cardiac Stents Heart Arrhythmia	CABG/Heart Bypass Pacemaker/Defibrillator Emphysema/COPD Asthma/Bronchitis	Pulmonary Embolus Blood Clots/DVT Sleep Apnea (CPAP) Anemia	Blood Transfusion Cancer Reflux/Ulcer Seizures
	Other:		

REVIEW OF SYSTEMS

* As you review the following list, please circle ALL which have significantly affected you:

MUSCULOSKELETAL Joint Pain Joint Swelling Joint Stiffness Muscle Pain Instability	**RESPIRATORY** Shortness of Breath Wheezing Cough	**EARS, NOSE & THROAT** Corrective Lenses Blurred/Double Vision Eye Pain Headache Difficulty Swallowing Nose Bleeds Earaches	**RENAL** Difficult/Painful Urination Frequency Urgency Incontinence
NEUROLOGIC Numbness/ Tingling Dizziness Nervousness Anxiety Seizures Tremors Balance Disturbances	**GASTROINTESTINAL** Heartburn Nausea Vomiting Constipation Diarrhea	**HEMATOLOGIC** Easy Bleeding Easy Bruising	**GENERAL** Unexpected Weight Loss Unexpected Weight Gain Fever Chills Fatigue
	SKIN Skin Changes Poor Healing Rash Itching	**ENDOCRINE** Excessive Thirst Excessive Urination Heat or Cold Intolerance	**CARDIOVASCULAR** Chest Pain Palpitations Fainting

NOTES:

_____

_____

PREVIOUS OPERATIONS *Please list:

Type	Year	Reason
1.		
2.		
3.		
4.		

Have you ever had anesthesia complications? No Yes
Please describe if answered Yes: _____

_____

Do you have a pain management contract? No Yes With which doctor or hospital? _____

I authorize the following people to pick up my prescriptions: _____

Are you taking any Blood Thinning medications, i.e. Coumadin____ Warfarin____ Plavix____ Xarelto____ Effient____ Pradaxa____ Eliquis____ Aspirin____ Other: _____

CURRENT MEDICATIONS *if you are providing your own list, circle here: MY MED LIST

Medication Name	Dose	What is the medication prescribed for?
1.		
2.		
3.		
4.		

ALLERGIES: Medications, Solutions or Metal

Medication, Solution or Metal Name	Allergic Reaction
1.	
2.	
3.	
4.	

FAMILY HISTORY

PLEASE INDICATE WITH RELATIONSHIP (i.e. father): Do you know of any blood relatives who have or have had any of the following?

Cancer	Diabetes	Epilepsy
Heart Disease	High Blood Pressure	Psoriasis
Congenital Problems	Obesity	Asthma
Alcoholism	TB	Thyroid Problems
Rheumatic Fever	Rheumatoid Arthritis	Stroke
Other:		

SOCIAL HISTORY

Tobacco Use?
Snuff No___ Yes___
E-Cigarettes No___ Yes___
Cigarettes: _____ packs a day
None___ Quit date _____

Drug Use?
Meth No___ Yes___
Cocaine No___ Yes___
Marijuana No___ Yes___
IV Drugs No___ Yes___

Alcohol Use?
Do you drink No___ Yes___
Drinks per week_____

Employment
Employer: _____ Occupation: _____ Unemployed Disabled Retired