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**Medical History Form**

NAME:

DOB:

DATE:

ALLERGIES:

# List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don’t know, please call your pharmacist to confirm.

# Pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications OTC and vitamins**

**PERSONAL MEDICAL HISTORY:** (Please circle/fill in all that apply)

ADHD COPD High Cholesterol Peptic Ulcer

Alcoholism Dementia HIV Psoriasis

Allergies, Seasonal Depression Hepatitis Pulmonary Embolism (PE) Anemia Diabetes: 1 or 2 Irritable Bowel Syndrome Rheumatoid Arthritis

Anxiety Diverticulitis Kidney Stones Sciatica Arrhythmia (irregular heart beat) DVT (Blood Clot) Kidney Disease Seizure Disorder Arthritis Eczema Lupus Sleep Apnea

Asthma Emphysema Liver Disease Stroke

Bipolar Gallstones Macular Degeneration Thyroid Disorder

Bladder problems/Incontinence GERD (Acid Reflux) Migraines Ulcerative Colitis Bleeding problems Glaucoma Nosebleeds

|  |  |  |
| --- | --- | --- |
| Last Menstrual Period | Yes/No  Date: | Normal  Abnormal |
| Colonoscopy | Yes/No  Date: | Normal  Abnormal |
| Mammogram | Yes/No  Date: | Normal  Abnormal |
| Dxa (Bone Density) | Yes/No  Date: | Normal  Abnormal |

Cancer: Heart Disease Neuropathy

Carpal Tunnel Heart Attack (MI) Osteopenia/Osteoporosis

Headaches Hiatal Hernia Parkinson’s Disease

Crohn’s Disease High Blood Pressure Peripheral Vascular Disease

# Other medical problems not listed above:

**Surgical History:** Please list all prior surgeries and approximate dates performed.

# SOCIAL HISTORY:

Recreational Drug Use: Current / Past / Never

Smoking: Currently Past Never Packs/day:

Alcohol: Currently Past Never Drinks/day:

# FAMILY HISTORY:

|  |  |  |  |
| --- | --- | --- | --- |
| **FATHER:** Living: | Age | Deceased: Age |  |
| Alcoholism | Blood Cancer | Migraines | Bipolar Osteoporosis |
| COPD/Emphysema | Skin Cancer | Colon Cancer | High Cholesterol |
| Stroke | Heart Disease | Lymph Cancer | Thyroid disorder |
| Anemia | Asthma | Breast Cancer | Dementia |
| Blood Clot/DVT | Depression | Kidney Disease | Prostate Cancer |
| Arthritis | High Blood Pressure | Diabetes 1 or 2 | Thyroid Cancer |

Other:

|  |  |  |
| --- | --- | --- |
| **MOTHER:** Living: | Age | Deceased: Age: |
| Alcoholism | Breast Cancer | Migraines Bipolar Osteoporosis |
| COPD/Emphysema | Blood Cancer | Colon Cancer High Cholesterol |
| Stroke | Heart Disease | Skin Cancer Thyroid disorder |
| Anemia | Asthma | Lymph Cancer Dementia |
| Blood Clot/DVT | Depression | Kidney Disease Ovarian Cancer |
| Arthritis | High Blood Pressure | Diabetes 1 or 2 Thyroid Cancer |

Other:

# Siblings:

**List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, etc.)**

Patient signature: Date:

Provider reviewed: Date: