

Name: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Pharmacy Name & Location: \_\_\_\_\_

**Allergies:**

Please list all current allergies and reactions:

NAME:	REACTION:

**Family History:**

Please list history of family illness in your immediate family:

Family Member	Maternal	Paternal	ILLNESS:

**Social History:**

Please provide your social history, mark **YES** or **NO** and put in frequency.

TYPE:	YES	NO	Never	Former	FREQUENCY:
SMOKER:					
ALCOHOL:					
DRUG USE:					



## Medical History:

Please check under the (+) sign if you have had any of the conditions listed below:

CATEGORY	+	DISORDER
Cardiovascular		Angina
		Atrial Fibrillation
		Bradycardia
		Cardiomyopathy
		Chest Pain
		Congestive Heart Failure
		Coronary Heart Disease
		Heart Murmur
		High Blood Pressure (Hypertension)
		High Cholesterol (Hypercholesterolemia)
		Mitral Valve Prolapse
		Palpitations
		Prosthetic Heart Valve
		Rheumatic Heart
		Completed Stroke
Dermatology		Tachycardia
		Alopecia
		Cellulitis
		Dermatitis
		Eczema
		Psoriasis
Endocrine		Skin Cancer
		Diabetes Mellitus
		Hyperthyroidism
		Hypothyroidism
		Lupus
ENT		Simple Goiter
		Change in sense of smell (Anosmia)
		Deafness
		Hearing Loss
		Hoarseness or change in voice
		Sinusitis
		Swallowing Difficulties (Dysphagia)
		Tinnitus
		Vertigo (Dizziness)
		Vocal Cord Polyps
GI		Abdominal Aortic Aneurysm
		Appendicitis
		Celiac Disease
		Liver Disease
		Cirrhosis of the Liver
		Diverticulitis
		Diverticulosis
		Reflux – Esophageal or Gastrointestinal
		Esophagitis
		Gastric Ulcer
		Hernia
		Ulcer



		Osteomyelitis
		Spinal Stenosis
Neurological		Alzheimer's Disease
		Aneurysm
		Bacterial Meningitis
		Cerebral Palsy
		Dementia
		Epilepsy
		Headaches
		Meningitis
		Migraine Headache
		Multiple Sclerosis
		Paralysis
		Parkinson's disease
		Seizure Disorder
Nutritional		Eating Disorder
		Obesity
Obstetrical		Breast Cancer
		Lump in Breast
		Endometriosis
		Fibrocystic Breasts
		Fibroid Uterus
		Osteoporosis
		Ovarian Cysts
Ophthalmology		Blindness L/ R/ Both
		Conjunctivitis L/ R/ Both
		Glaucoma L/ R/ Both
Psychiatric		Alcohol-Induced Mental Disorders
		Bipolar Disorder
		Autistic Disorder
		Depression
		Obsessive Compulsive Disorder
		Personality Disorder
Respiratory		ARDS
		Asthma
		Bronchitis
		Cystic Fibrosis
		Emphysema
		Lung Cancer
		Lung Disease
		Pleurisy
		Pneumonia
		Pulmonary Fibrosis
		Seasonal Allergies (Allergic Rhinitis)
		Sleep Apnea- CPAP Machine: Yes/ No    Setting:
Other		