Place Patient Label Here

Pharmacy & Location:

____

____

____

Patient History Form

****Please Print****

Patient Name: ______________________________ **DOB:**______________ **Date:**________________

DRUG ALLERGIES *(Please list the name and reaction)*

CURRENT MEDICATIONS *(Please list any prescription, herbal or over the counter)*

DO YOU OR HAVE YOU EVER USED THE FOLLOWING *(Please list what, when & how much)*:

Smoking or tobacco:		
Alcohol:		
Recreational drugs:		

MEDICAL HISTORY *(Please check all that apply)*

- ☐ ADD/ADHD
- ☐ Allergic rhinitis
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Cataracts
- ☐ CHF
- ☐ Clotting disorder
- ☐ COPD
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Eating disorder
- ☐ Eczema
- ☐ Emphysema
- ☐ Failure to thrive
- ☐ GERD
- ☐ Glaucoma
- ☐ Headache
- ☐ Hearing loss
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Tuberculosis
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Meningitis
- ☐ Myocardial infarction
- ☐ Nerve/muscle disease
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Scoliosis
- ☐ Seizures
- ☐ Thyroid disease
- ☐ Inflammatory bowel disease
- ☐ Ulcers (GI)
- ☐ Varicella
- ☐ Vision problems
- ☐ Other:________________

SURGICAL HISTORY *(Please check all that apply)*

- ☐ Adenoidectomy
- ☐ Appendectomy
- ☐ Brain surgery
- ☐ Breast surgery
- ☐ CABG
- ☐ Cholecystectomy
- ☐ Colon surgery
- ☐ Cosmetic surgery
- ☐ C-Section
- ☐ Eye surgery
- ☐ Fracture surgery
- ☐ Gastrostomy
- ☐ Heart surgery
- ☐ Hernia repair
- ☐ Hysterectomy
- ☐ Inguinal hernia
- ☐ Joint replacement
- ☐ Lymph node biopsy
- ☐ Small intestine surgery
- ☐ Spine surgery
- ☐ Tubal ligation
- ☐ Umbilical hernia
- ☐ Valve replacement
- ☐ VP shunt
- ☐ Other:________________

FAMILY HISTORY

MEDICAL PROBLEM	FAMILY MEMBER	AGE OF ONSET

#13922 (12-2024)