PATIENT HISTORY FORM

NOTE: THIS IS A CONFIDENTIAL RECORD AND WILL BE KEPT IN YOUR DOCTOR'S OFFICE. INFORMATION CONTAINED HERIN WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR AUTHORIZATION TO DO SO.

TODAY'S DATE: _____ DATE OF LAST PHYSICAL EXAM: _____

LAST NAME:_____ FIRST NAME:_____ MIDDLE INITIAL:_____

SOCIAL SECURITY NO:_____ DATE OF BIRTH:_____ PHONE NO:_____

PHARMACY NAME: _____ PHARMACY LOCATION: _____REFERRING DOCTOR:_____

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? (DESCRIBE YOUR PROBLEM IN DETAIL)

_____

_____

_____

PHYSICIAN USE ONLY (COMMENTS/NOTES)

# ANSWERS	LEVEL OF SERVICE
1-3	1 OR 2
4+	3 - 5

FAMILY HISTORY

LIST ALL SERIOUS ILLNESSES (DIABETES, TUBERCULOSIS, BREAST CANCER, HEART DISEASE, ETC) IN YOUR IMMEDIATE FAMILY

_____ _____

_____ _____

_____ _____

LIST ANY PERSONAL PAST ILLNESS AND/OR SURGERIES AND WHEN THEY OCCURRED

ILLNESS OR SURGERY	DATE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ARE YOU ON ANY MEDICATIONS? Y N (IF YES, LIST ALL)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ARE YOU ON A SPECIAL DIET? Y N (IF YES, PLEASE EXPLAIN)

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? Y N

IF SO, PLEASE LIST BELOW:

_____ _____

_____ _____

_____ _____

_____ _____

DO YOU SMOKE? Y N

(IF YES, PLEASE LIST BELOW)

IF YES, HOW MUCH? _____

DO YOU DRINK ALCOHOL? Y N

IF YES, HOW MUCH? _____

DO YOU DRINK COFFEE? Y N

IF YES, HOW MUCH? _____

DO YOU DRINK TEA? Y N

IF YES, HOW MUCH? _____

DO YOU EAT CHOCOLATE? Y N

IF YES, HOW MUCH? _____

DO YOU DRINK SOFT DRINKS? Y N

IF YES, HOW MUCH? _____

PHYSICIAN USE ONLY (COMMENTS/NOTES)

# ANSWERS	LEVEL OF SERVICE
0	1 OR 2
1 – 2	3
3	4 OR 5