

PATIENT HISTORY FORM

NOTE: THIS IS A CONFIDENTIAL RECORD AND WILL BE KEPT IN YOUR DOCTOR'S OFFICE. INFORMATION CONTAINED HEREIN 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