Name _____ DOB:_____ Date _____

Marital status (circle one): Single Married Divorced Separated Widowed

Sex: Female Male

Who referred you? _____

Reason for coming in? _____
_____

Are you allergic to any medications? _____

What medications are you currently taking?

1) _____ 2) _____
3) _____ 4) _____
5) _____ 6) _____
7) _____ 8) _____
9) _____ 10) _____

Please write your ***pharmacy name and city***: _____

Please indicate which of the following you have or have had in the past. Circle yes or no.

Asthma	Yes No	Heart Problem	Yes No
Arthritis	Yes No	Hepatitis	Yes No
Blood Transfusion	Yes No	Lung Disease	Yes No
Cancer	Yes No	Osteoporosis	Yes No
Depression	Yes No	Pacemakers	Yes No
Diabetes	Yes No	Stroke	Yes No
Epilepsy/Seizures	Yes No	Thyroid	Yes No
Glaucoma	Yes No	Ulcers	Yes No
High Blood Pressure	Yes No	Venereal Disease	Yes No
High Cholesterol	Yes No	Pancreatitis	Yes No
		Other:_____	

Name:_____ DOB:_____ Date:_____

Do you have a family history of any of the previous conditions? If yes, list which one.

_____

_____

_____

Other disease not listed that you have or may have had in the past. _____

_____

****Women only****

How many times have you been pregnant? _____
How many children do you have? _____
How old were you when you had your first child? _____
1st day of last menstrual period? _____
Date that menopause began: _____
Date of last Pap smear? _____
Have you ever had an abnormal pap smear? Yes No
If yes, what were the date(s) and the outcome?

_____
Date of last Mammogram? _____
Have you ever had an abnormal Mammogram? Yes No
If yes, what was the outcome? _____
Have you had your uterus removed (Hysterectomy)? Yes No
If yes, what was the date and why was it removed? _____

_____
Have you had one or both ovaries removed? Yes No
If yes, what was the date and why were they removed? _____

_____

Past Surgical History

Have you had any surgery in the past? Yes No
If yes, what kind of surgery? _____

_____
When and where? _____

Name:_____ DOB:_____ Date:_____

Hospitalizations

Have you ever been hospitalized? Yes No
If yes, when were you hospitalized? _____
For what reason? _____
What hospital? _____

Social History

Do you smoke? Yes No
Do you use tobacco? Yes No
Do you drink alcohol? Yes No
Have you ever used any illegal narcotics? Yes No

Review of Symptoms

Describe your current symptoms. _____
_____
_____

For how long have they occurred? _____
_____