

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.

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

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**\*\*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?

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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? \_\_\_\_\_

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Have you had one or both ovaries removed? Yes No

If yes, what was the date and why were they removed? \_\_\_\_\_

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**Past Surgical History**

Have you had any surgery in the past? Yes No

If yes, what kind of surgery? \_\_\_\_\_

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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? \_\_\_\_\_

\_\_\_\_\_