PLEASE FULLY COMPLETE THIS FORM

Name:_____ Date of birth: _____

Local Phone:( )_____ Height:_____ Weight: _____

Local Pharmacy: _____ Last menstrual period:_____

Prescriptions are electronically sent to pharmacies

Medications: ☐See attached list

Medication Name	Dose	Medication Name	Dose

Allergies to medications: ☐See attached list ☐ No Known Drug Allergies

Medication Name:	Reaction:

Diagnosed Medical Conditions: Pacemaker ☐Yes ☐No

- ☐ A-Fib/Irregular Heart Beat
- ☐ Allergies
- ☐ Alzheimer's Disease
- ☐ Anxiety Disorder
- ☐ Arthritis:
  - ☐Rheumatoid ☐Osteoporosis
- ☐ Asthma
- ☐ Back Pain
- ☐ Blood Clot
- ☐ Cancer
  - Type:_____
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease
- ☐ Diabetes Mellitus
  - ☐Type I ☐Type II
- ☐ GERD (Acid Reflux)
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Hepatitis (A B C)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Disease
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Mental Illness
  - Type:_____
- ☐ Migraine
- ☐ Mitral Valve Disorder
- ☐ Multiple Sclerosis
- ☐ Neuropathy
- ☐ Ovarian Cysts
- ☐ Parkinson's
- ☐ Prostate Enlargement
- ☐ Renal Failure
- ☐ Seizure
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid disease
- ☐ TIA (Mini Stroke)
- ☐Other: _____

Social History:

Tobacco Use: ☐Yes ☐No ☐Past ☐Never

Alcohol Use: ☐Yes ☐Daily ☐Weekly ☐Occasionally ☐No ☐Past ☐Never

Caffeine Use: ☐Yes ☐No ☐Past ☐Never

Drug Use: ☐Yes ☐No ☐Past ☐Never

Family History: ☐Patient Adopted ☐Unknown ☐No Significant Medical History

- ☐ Heart Problems
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Diabetes Mellitus
  - ☐Type I ☐Type II
- ☐ Thyroid Disorder
- ☐ Glaucoma
- ☐ Mental Illness
  - Type:_____
- ☐ Arthritis
  - ☐Rheumatoid ☐Osteoporosis
- ☐ Alzheimer's Disease
- ☐ Dementia
- ☐ Migraine
- ☐ Stroke
- ☐ Cancer
  - Type:_____
- ☐ Blood Clot
- ☐ Tuberculosis
- ☐Other: _____

Previous Surgeries:

- ☐ Adenoidectomy
- ☐ Aortic Valve Repair
- ☐ Appendectomy(appendix)
- ☐ Artery Bypass Graft
- ☐ Breast Implantation
- ☐ Breast Reduction
- ☐ CABG(Open Heart)
- ☐ Cervical Spine Disk Surgery
- ☐ Cholecystectomy(gallbladder)
- ☐ Colectomy
- ☐ Dilation and Curettage (D&C)
- ☐ Gastric Bypass
- ☐ Heart Stent
- ☐ Hysterectomy
- ☐ Hernia Repair
- ☐ Low Back Disk Surgery
- ☐ Mastectomy/Lumpectomy
- ☐ Mitral Valve Replacement
- ☐ Nephrectomy(kidney)
- ☐ Shoulder Repair
- ☐ Thyroidectomy
- ☐ Total Hip Replacement
- ☐ Total Knee Replacement
- ☐ Tonsillectomy(tonsills)
- ☐ Tubal Ligation
- ☐Other: _____

Immunization Date:

Flu Vaccine: Pneumovax: Tetanus: Shingles: