Medical History

Patient Name: _____ Date of Birth____/____/____ Date____/____/____

Local Pharmacy: _____ Mail Order Pharmacy: _____

Reason for today's visit: _____

Are you allergic to any medications? ☐ Yes ☐ No List: _____

List all medications you are currently taking: _____

_____

_____

Do you have now, or have you ever had diseases or conditions of: (Please check Yes or No)

	Yes	No		Yes	No
Anxiety	☐	☐	GERD	☐	☐
Arthritis	☐	☐	Hearing Loss	☐	☐
Asthma	☐	☐	Hepatitis	☐	☐
Irregular Heart Beat	☐	☐	Hypertension	☐	☐
Bone Marrow Transplant	☐	☐	HIV/AIDS	☐	☐
BPH (Benign Prostate Hypertrophy)	☐	☐	Hypercholesterolemia	☐	☐
Breast Cancer	☐	☐	Thyroid Disease	☐	☐
Colon Cancer	☐	☐	Leukemia	☐	☐
COPD	☐	☐	Lung Cancer	☐	☐
Coronary Artery Disease	☐	☐	Lymphoma	☐	☐
Depression	☐	☐	Prostate Cancer	☐	☐
Diabetes	☐	☐	Radiation Treatment	☐	☐
End Stage Renal Disease	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Stroke	☐	☐
Artificial Heart Valve	☐	☐	Other: _____		

Do you have artificial joints? ☐ Yes ☐ No

Have you ever had a skin cancer? ☐ Yes ☐ No

Has anyone in your family had skin cancer? ☐ Yes ☐ No Who?_____

Do you smoke? ☐ Yes ☐ No If yes, how much?_____

Do you use IV drugs? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, how much?_____

Patient Signature _____ Date _____