

About You Today **Y** **N**

Chills _____

Fever _____

Night Sweats _____

Significant Weight Change _____

SKIN

Bruising _____

Pallor _____

Rash _____

HEENT

Headache/Migraine _____

Hearing Loss _____

Vertigo _____

RESPIRATORY

Cough _____

Difficulty Breathing _____

CARDIOVASCULAR

Calf Cramps _____

Chest Pain _____

Fainting _____

Irregular Heartbeat _____

Shortness of Breath _____

Swelling of Extremities _____

GASTROINTESTINAL

Bloody Stool _____

Constipation _____

Nausea _____

Vomiting _____

MUSCULOSKELETAL

Back Pain _____

Muscle Weakness _____

NEUROLOGY

Loss of Consciousness _____

Numbness/Tingling _____

Neuropathy _____

Weak in Extremities _____

PSYCHIATRIC

Anxiety _____

Depression _____

HEMATOLOGY

Abnormal Bleeding _____

Blood Clots _____

About You

Right Handed _____

Left Handed _____

Height _____

Orthopedic Surgical History

Allergies **Y** **N**

Latex _____

Metal _____

Iodine(topical or IVP) _____

Other _____

Reactions _____

Medication Allergy _____

No Known Allergies _____

Current Medications

| Name | Dosage |
|-------|--------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Social History

Check **Y or No**

Drug Use _____

Alcohol Use _____

Smoker How much? _____

Chew Tobacco _____

Exercise _____

Participate Sports _____

Perm Resident _____

Seasonal Resident _____

Circle one

Lives Alone or with Spouse or
With Adult Children or -Assisted living-
other _____

Do you Drive _____

Do You Work _____

Where? _____

Family History **Y** **N**

Alcohol Abuse _____

Arthritis _____

Cancer _____

Diabetes _____

Heart Disease _____

Hypertension _____

Hip Replacement _____

Knee Replacement _____

Pharmacy Information

Name _____

Phone # _____

Past Medical History

| Check for | Y | N |
|-----------------------|-------|-------|
| Aneurysm | _____ | _____ |
| Asthma | _____ | _____ |
| Arthritis | _____ | _____ |
| Balance Problems | _____ | _____ |
| Blood Clots | _____ | _____ |
| Cancer | _____ | _____ |
| Where? _____ | | |
| Cardiac Problems | | |
| Mitral Valve Disease | _____ | _____ |
| Heart Attack | _____ | _____ |
| Angina | _____ | _____ |
| Chronic UTI | _____ | _____ |
| Diabetes | _____ | _____ |
| Digestive Problems | _____ | _____ |
| Gout | _____ | _____ |
| Hepatitis What Type? | _____ | _____ |
| High BP | _____ | _____ |
| High Cholesterol | _____ | _____ |
| H.I.V. | _____ | _____ |
| Lung Problem | _____ | _____ |
| Kidney Disease/Stones | _____ | _____ |
| Lupus | _____ | _____ |
| Muscular Dystrophy | _____ | _____ |
| Pancreatitis | _____ | _____ |
| Polio | _____ | _____ |
| Shingles | _____ | _____ |
| Sleep Apnea | _____ | _____ |
| Stroke | _____ | _____ |
| Thyroid Disease | _____ | _____ |
| Ulcers What type? | _____ | _____ |
| Other _____ | | |

Other Surgical History

| | | |
|-----------------|-------|-------|
| Abdominal | _____ | _____ |
| Appendectomy | _____ | _____ |
| Bladder | _____ | _____ |
| Breast Biopsy | _____ | _____ |
| Cataract Rem | _____ | _____ |
| Colonoscopy | _____ | _____ |
| Colostomy | _____ | _____ |
| Gall Bladder Sx | _____ | _____ |
| Heart Sx | _____ | _____ |
| Hemorrhoids | _____ | _____ |
| Hernia | _____ | _____ |
| Hysterectomy | _____ | _____ |
| Mastectomy | _____ | _____ |
| Prostate | _____ | _____ |
| Tonsillectomy | _____ | _____ |
| Other _____ | | |

**I give permission to pull my medications
from my pharmacy. Y N**

I have given correct information above

Signature of patient