

NAME: _____ **AGE:** _____ **PREFERRED PHARMACY:** _____
REFERRED BY? _____ **HEIGHT:** _____ **WEIGHT:** _____
PRIMARY CARE DOCTOR: _____

CHIEF COMPLAINT (main problem that you're here for today):

PAST AND CURRENT MEDICAL PROBLEMS (please circle and fill in appropriate spaces):

Heart Problems Heart Attack High Blood Pressure Stroke Environmental or Food Allergies Asthma
Emphysema Diabetes Sleep Apnea Hypothyroidism Reflux Glaucoma Migraines
Cancer of the: _____ Need Antibiotics for Dental Procedures
Other: _____

PAST SURGERIES (please circle and fill in appropriate spaces):

Ear Tubes Adenoidectomy Tonsillectomy Sinus surgery Septoplasty Thyroid surgery
Heart bypass Angioplasty Pacemaker Lung surgery Metal Implants in the Body
Other: _____

CURRENT MEDICATIONS (name of medication, dosage, and frequency):

ALLERGIES TO MEDICATIONS (name of medication and type of allergic reaction):

SOCIAL HISTORY (please circle and fill in as appropriate):

Smoking/Chewing tobacco YES NO Packs/Tins per day: _____ Number of years: _____ Quit when? _____
Alcohol YES NO Drinks per week: _____
Caffeine YES NO Drinks per day: _____
Pets at home YES NO What type(s)? _____
Pregnant YES NO NOT APPLICABLE
Daycare YES NO NOT APPLICABLE
Occupation _____

REVIEW OF SYSTEMS (please circle those that apply TODAY):

GENERAL:	fever/chills	weight loss/gain	fatigue
LUNGS:	cough	coughing up blood	shortness of breath
ALLERGIES:	seasonal allergy	allergy testing done	allergy shots done
EYES:	itching	tearing	blurred vision
CARDIAC:	chest pain	irregular heartbeat	murmur
GASTROINTESTINAL:	heartburn/indigestion	nausea/vomiting	swallowing difficulty
GENITOURINARY:	bloody urine	pain with urination	bedwetting (kids)
MUSCULOSKELETAL:	arthritis	muscle cramps	muscle pain
NEUROLOGIC:	dizziness	headaches	seizures
SKIN:	growths/lesions	hives	rashes
PSYCHIATRIC:	depression	anxiety	sleep disturbances
ENDOCRINE:	heat/cold intolerance	eyes bulging out	excessive thirst/hunger/urination
HEMATOLOGIC:	clotting problem	easy bruising	swollen lymph glands

FAMILY HISTORY (please circle and fill in appropriate spaces):

Bleeding/Clotting problems Environmental allergies Thyroid problems Other: _____

EMERGENCY CONTACT NAME _____ **PHONE** _____ **PATIENT** _____

SIGNATURE (I state that the above information is correct): _____