

Medical History

Name _____ Date of Birth _____

Pharmacy Name _____ Phone _____

Pharmacy Address _____

Have you ever been treated for any of the following medical problems? (please circle)

High blood pressure	diabetes	depression
Heart disease	thyroid disorders	anemia
High cholesterol	liver disease	cancer
Lung disease	kidney disorders	muscular disorders
Stomach/intestinal disorders		nerve disorders

Have you received any blood transfusions? Yes No Year(s) _____

Current Medications:

Drug Allergies:

Reactions:

Hospitalization:

Have any of your blood relatives been diagnosed or treated for any of the following?

Colon cancer	heart disease	diabetes
Prostate cancer	high blood pressure	thyroid disorders
Breast cancer	high cholesterol	seizures
Leukemia	stroke	bleeding disorders

Social History:

Marital status: married single divorced widowed live with significant other
Do you use tobacco now? Yes No How much? _____ How long? _____
Did you use tobacco in the past? Yes No When did you quit? _____
Do you use alcoholic beverages? Yes No Type and weekly amount _____
Have you ever used illicit drugs? Yes No Type and amount _____

Immunizations:

Date of last: tetanus _____ pneumonia vaccine _____
Influenza _____ hepatitis B series _____