Patient History

Patient Name _____ Date _____

Medication History:

Do you have any allergies? Please circle: Yes No If yes, please list allergen, including reaction: _____

_____

_____

Please list all medications that you are currently taking: **(Please use back of form if additional space is needed)**

Presciption name:	_____	Dosage/Instructions:	_____
Presciption name:	_____	Dosage/Instructions:	_____
Presciption name:	_____	Dosage/Instructions:	_____
Presciption name:	_____	Dosage/Instructions:	_____
Presciption name:	_____	Dosage/Instructions:	_____

Do we have your permission to verify these presecriptions via SureScripts? Yes No

Patient Signature: _____ Date: _____

Medical History:

Do you have or have you ever had any of the following? Please circle Yes or No next to each of the following.

Cardiovascular:

Heart attack	Yes	No
High blood pressure	Yes	No
Stroke	Yes	No
Other heart/vascular disease	Yes	No

if yes, specify: _____

_____

Blood:

Diabetes	Yes	No
High cholesterol	Yes	No
Anemia	Yes	No
Bleeding disorder	Yes	No
Thyroid disease	Yes	No
Other blood disorder	Yes	No

if yes, specify: _____

_____

Respiratory:

Asthma	Yes	No
Chronic Bronchitis	Yes	No
COPD	Yes	No
Weak Lungs	Yes	No
Other respiratory disease	Yes	No

if yes, specify: _____

_____

Digestive:

Gall Bladder disease	Yes	No
Gastric ulcers	Yes	No
Colitis	Yes	No
Other digestive disease	Yes	No

if yes, specify: _____

_____

If you have any other chronic conditions that are not listed, please specify below:

_____

_____

_____

Surgical History:

Have you had any surgeries? Please circle: Yes No **(Please use back of form if additional space is needed)**

If yes, please specify all past surgeries, including date(s): _____

_____

_____

_____

Patient History

Patient Name _____ Date _____

Tobacco History:

Please circle and fill in the appropriate answers.

Non-smoker Yes No

Current smoker Yes No

if yes: How often do you smoke? Everyday Some days

How much do you smoke? 5 or less 6-10 11-20 21-30 31 or more

How soon after waking up? 1-5 mins. 6-30 mins. 31-60 mins. after 60 mins.

Are you curreny? Ready to quit Thinking about quitting Not ready to quit

Former smoker Yes No

if yes: How much did you smoke? _____

For how long and when did you quit? _____

Alcohol History:

Do you drink alcoholic beverages? Please circle: Yes No

if yes: How often? Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week

How much? 1-2 drinks 3-4 drinks 5-6 drinks 7-9 drinks 10 or more drinks

How often have you had 6 or more drinks on one occasion in the past year? _____

Family History:

Please circle and fill in the appropriate answers.

		Circle:		Circle:		Please list diseases/conditions:
Father:	Age: _____	Alive	Deceased			_____
Mother:	Age: _____	Alive	Deceased			_____
Siblings:	Age: _____	Alive	Deceased	Brother	Sister	_____
	Age: _____	Alive	Deceased	Brother	Sister	_____
	Age: _____	Alive	Deceased	Brother	Sister	_____
	Age: _____	Alive	Deceased	Brother	Sister	_____
	Age: _____	Alive	Deceased	Brother	Sister	_____
Spouse:	Age: _____	Alive	Deceased			_____
Children:	Age: _____	Alive	Deceased	Son	Daughter	_____
	Age: _____	Alive	Deceased	Son	Daughter	_____
	Age: _____	Alive	Deceased	Son	Daughter	_____
	Age: _____	Alive	Deceased	Son	Daughter	_____

Vaccination History:

Have you recently had any of the follwing vaccinations? Please circle and specify:

Flu	Yes	No	Most recent date:	_____
Pneumonia	Yes	No	Most recent date:	_____
Shingles	Yes	No	Most recent date:	_____

Additional Comments: _____