

PERSONAL MEDICAL HISTORY

Note: This is a confidential report of your medical history.
Information contained here will be released only if you have authorized us to do so.

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ____/____/____ Sex: Female Male Marital Status: _____

Preferred Pharmacy: _____ Pharmacy Phone #: _____

Pharmacy Address: _____

PCP: _____ Referring Doctor: _____

Past Medical History:

Check any conditions you have had:

- | | |
|--|---|
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Anemia | (Overactive Thyroid) |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Asthma | (Underactive Thyroid) |
| <input type="checkbox"/> Bone Disease | <input type="checkbox"/> Impotence/ED |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease |
| Type: _____ | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Meningitis |
| (Heart Disease) | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Nipple Discharge |
| <input type="checkbox"/> Diabetes Type I | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Dyslipidemia | <input type="checkbox"/> Postmenopausal |
| (High Cholesterol) | Bleeding |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Endocrine Disorder | <input type="checkbox"/> Serious Injury |
| <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Cancer |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid Nodule |
| (High Blood Pressure) | <input type="checkbox"/> Tuberculosis |

Have you ever had External Beam Neck Radiation?

No Yes Date: _____

Other major diseases: _____

Health Maintenance: Fill in all that apply

Date of last eye exam: _____

Date of last prostate exam: _____

Date of last PAP test: _____

Previous mammogram: _____

Glasses or contacts? No Yes Both

Past Surgical History:

Have you ever had surgery? Yes No

If yes, please list:

Type: _____ Year: _____

Type: _____ Year: _____

Type: _____ Year: _____

Recent Hospitalizations: _____

Medications:

List all medicines and supplements you take:

Medicine or Supplement	How much?	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

Are you allergic to any medications? Yes No

Please list: _____

Are you allergic to latex? Yes No

Are you allergic to any foods? Yes No

Please list: _____

Family History: Parents, Grandparents, Brothers, Sisters, Children, Aunts and Uncles		Social History:	
Yes	No	Disease:	Relative(s):
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	
<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	
<input type="checkbox"/>	<input type="checkbox"/>	Other Glandular Disease	
<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease/ Goiter	
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	
Do you use alcohol?		<input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Some Days <input type="checkbox"/> Everyday	
Do you drink caffeinated beverages?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever smoked?		<input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Some Days <input type="checkbox"/> Everyday	
If yes, how many years have you smoked? _____		Packs per day? _____	
How often do you exercise?		<input type="checkbox"/> Never <input type="checkbox"/> 1x per wk <input type="checkbox"/> 2-3x per wk <input type="checkbox"/> 4+x per wk	
Are your parents living?		<input type="checkbox"/> Mom <input type="checkbox"/> Dad	
How many siblings do you have? _____		How many children do you have? _____	
Highest level of education? _____		Occupation: _____	

Symptoms: Please check the appropriate boxes indicating the symptoms you have had within the last year.

CONSTITUTIONAL

- Change in weight of more than 10 lbs.
- Night Sweats
- Fatigue

EYES

- Trouble with Vision
- Changes in Vision
- Double Vision
- Blurred Vision

HEAD ENT

- Changes in Hearing
- Hoarseness
- Headaches

BREASTS

- Changes in Skin
- Masses
- Nipple Discharge

PSYCHIATRIC

- Anxiety
- Depression
- Difficulty Breathing

CARDIOVASCULAR

- Palpitations
- Chest Pain
- Difficulty Breathing on Exertion
- Lower Extremity Swelling
- Loss of Consciousness

RESPIRATORY

- Chronic Cough
- Coughing Blood
- Shortness of Breath
- Wheezing
- Difficulty Breathing

GASTROINTESTINAL

- Difficulty Swallowing
- Reflux
- Nausea
- Vomiting
- Vomiting Blood
- Diarrhea
- Constipation
- Blood in Stools
- Changes in Bowel Habits

GENITOURINARY

- Painful or Difficult Urination
- Frequency
- Excessive Urination at Night
- Post Void Dribbling
- Blood in Urine
- Urgency

INTEGUMENT/SKIN

- Pigmentation Changes
- Skin Dryness
- Rash
- New Skin Lesions
- Changes to Existing Skin Lesions/Moles
- Hair Growth Change

NEUROLOGIC

- Tremors
- Speech Difficulties
- Paralysis
- Tingling or Numbness
- Seizures
- Muscular Weakness

MUSCULOSKELETAL

- Muscle Cramps
- Nocturnal Leg Cramps
- Joint Pain
- Joint Swelling

ENDOCRINE

- Cold Intolerance
- Heat Intolerance
- Drinking More Fluids
- Excessive Urination
- Excessive or Abnormal Thirst
- Excessive Hair Growth
- Hot Flashes

HEMA-LYMPH

- Lymph Node Enlargement
- Easy Bleeding
- Easy Bruising

ALLERGIC-IMMUNO

- Sinus Allergy
- Hay Fever
- Allergic Dermatitis

I certify these two pages to be accurate and current to the best of my knowledge (Please sign and date below)

Patient Signature: _____ Date: _____