Name: _____Date of Birth: _____

ALLERGIES OR REACTIONS TO MEDICATIONS:

NAME OF MEDICATION	REACTION

CURRENT MEDICATIONS (Prescription, Non-prescription, vitamins, etc.)

NAME OF MEDICATION	DOSAGE	HOW MANY TIMES PER DAY

PHARMACY NAME AND LOCATION:

_____

Name of Mail Order Pharmacy: _____ **Mail Order Pharmacy ID#** _____

If you have **Medicare D(prescription coverage) Company Name and ID #: _____**

PAST MEDICAL HISTORY: HAVE YOU EVER HAD ANY OF THE FOLLOWING? Circle all that apply:

Measles	Anemia	Back Trouble	Hemorrhoids
Mumps	Blood/Plasma Transfusion	Arthritis	Hernia
Chickenpox	Infectious Mono	Gout	Ulcer
Whooping Cough	Hepatitis/Jaundice	Diabetes	Irritable Bowel Syndrome
Scarlet Fever	Bleeding Tendency	Glaucoma	Frequent Bladder Infections
Diphtheria	Blood Clots	Bronchitis	Kidney Disease
Smallpox	Heart Disease	Asthma	Liver Disease
Pneumonia	Low Blood Pressure	Emphysema	Thyroid Disease
Rheumatic Fever	High Blood Pressure	Migraine Headaches	Gallbladder Disease
Tuberculosis	Mitral Valve Prolapse	Cancer	Alcoholism
Polio	Stroke/TIA	Venereal Disease	Mental Illness
Epilepsy/Seizure	Heart Murmur	AIDS/HIV	Hives/Eczema

Immunizations: Please provide dates if known

Influenza (flu) _____Tetanus (Td)_____Pneumococcal _____Prevnar _____
Hepatitis A _____ Hepatitis B_____Measles (MMR) _____Shingles_____

Health Screening:

Colonoscopy Date:_____ Findings Normal? **Yes/ No** Physician:_____

Bone Density Date:_____Findings Normal? **Yes/ No**

Eye Exam Date:_____ Physician: _____ Do you wear glasses or contacts?

Foot Exam Date: _____ Physician:_____

TB Test Date: _____Findings Normal? **Yes/ No** Do you wear hearing aids? **Yes/ No**

Ladies:

Last Pap Smear Date: _____Findings Normal? **Yes/ No** Last Mammogram Date: _____

Gentlemen:

Last PSA Date: _____ Findings Nomal? **Yes/ No** Ordering Physician _____

Past Surgical History:

Type of Surgery	Date of Surgery	Surgeon

PAST SERIOUS ILLNESS:

ILLNESS	DATE

FAMILY HISTORY:

Is your Mother still living? **Yes/ No** If deceased, at what **age**? _____ **Cause of Death**: _____

Any other health problems: _____

Is your Father still living? **Yes/ No** If deceased, at what **age**? _____ **Cause of Death**:_____

Any other health problems_____

Does/did any other close blood relative have any health problems such as heart disease, high blood pressure, diabetes, cancer, etc? _____

_____

_____

Social History:

Relationship Status: (Please Circle) **Single Married Divorced Separated Widowed**
Caffeine (Cups per day) **Coffee** _____ **Tea** _____ **Soda** _____ **Energy Drinks** _____
Exercise Regularly? **Yes/ No** Do you use any Recreational Drugs? **Yes/No**

TOBACCO HISTORY:
Do you currently use tobacco? **Yes / No** ____Cigarettes ____Cigars ____Pipe ____ Smokeless ____ Vape

Have you used Tobacco in the past? **Yes /No** How much do/did you smoke per day? _____ How long?_____

ALCOHOL HISTORY:
Do you drink alcohol: **Social/ Occasionally Daily Weekly How Much** _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my physician's office of any changes in my medical status.

_____ _____

Patient's Signature **Date**