□ JEB □ CDB □ KAM □ CWP □ JCC DATE: _____

Health History Form

NAME: _____ Date of Birth: _____ Age: _____

Address: _____

Pharmacy Name: _____ Phone: _____

Pharmacy Location: _____

Primary Care Physician: _____ Phone: _____

REASON FOR VISIT

What body part(s) are you being seen for today? _____

Is this chronic or acute? _____

Have you had any of the following tests **pertaining to your visit today**?

□ CT Scan □ MRI □ EMG □ X-RAYS □ Physical Therapy □ Injections □ Bone Scan

Is this related to an injury? □ NO □ YES Date of Injury: _____

Is this sports related? □ NO □ YES Name of sport: _____

PERSONAL MEDICAL HISTORY

_____

_____

_____

_____

_____

_____

ARE YOU BEING TREATED FOR ANY OF THE FOLLOWING?

Hypertension	□ NO □ YES	Do you have a pacemaker?	□ NO □ YES
Diabetes	□ NO □ YES	Do you have aneurysm clips?	□ NO □ YES
Asthma	□ NO □ YES	Do you have low back pain?	□ NO □ YES
Ischemic Heart Disease	□ NO □ YES	Heart Failure	□ NO □ YES

Date of Flu Vaccine (approximate): _____

AGE 65 AND OVER:

Date of Pneumonia Vaccine (approximate): _____

Have you fallen in the last year: □ NO □ YES

PAST SURGERIES	**DATE**

NAME: _____ DATE: _____

HOSPITALIZATIONS	DATE

SOCIAL HISTORY

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Lives with: □ Spouse/Partner □ Parents □ Children □ Friend(s)
□ Retirement Community □ Nursing Home □ Alone

Smoked Tobacco Usage: □ Current □ Former □ Never

Do you drink alcohol? □ NO □ YES

How often do you drink? _____

EMERGENCY CONTACT (NAME, RELATION, PHONE NUMBER)

_____

CURRENT EMPLOYMENT (PLACE OF EMPLOYMENT AND POSITION TITLE)

_____

PLEASE DESCRIBE THE NATURE OF YOUR EMPLOYMENT (PHYSICAL DEMANDS OF YOUR JOB)

_____

_____

_____

FAMILY MEDICAL HISTORY

FAMILY MEMBER	PROBLEM

NAME: _____ DATE: _____

PLEASE LIST ALL MEDICATIONS (PRESCRIPTIONS AND OVER-THE-COUNTER)		
NAME OF MEDICATION	**DOSAGE**	**REASON**

Are you using any birth control medication or devices?	□ NO	□ YES
Are you taking any hormone replacements?	□ NO	□ YES
Do you have sleep apnea?	□ NO	□ YES
Do you have a history of blood clots/deep vein thrombosis (DVT)?	□ NO	□ YES
Have you ever had a pulmonary embolism (PE)?	□ NO	□ YES
Do you have an allergy to metal?	□ NO	□ YES
Do you have an allergy to meat (Alpha Galactose)?	□ NO	□ YES

Are you taking any of the following anticoagulants (blood thinners)?

□ Aspirin □ Eliquis □ Factor 10 □ Pradaxa □ Warfarin/Coumadin

□ Plavix □ Xarelto □ Brilinta □ Other: _____

ALLERGIES: _____

SEASONAL ALLERGIES: _____

NAME: _____ DATE: _____

REVIEW OF SYSTEMS

Please select all that currently apply.

General	
	Anorexia
	Change in appetite
	Chills
	Fatigue
	Fever
	General weakness
	Insomnia
	Malaise
	Sweats
	Weight decrease
	Weight increase

Eyes	
	Blurred vision
	Double vision
	Dry eyes
	Eye discharge
	Eye itch
	Eye pain
	Glasses/Contacts
	Photophobia
	Scotoma
	Visual Disturbances
	Vision Loss

Ears/Nose/Throat	
	Bleeding gums
	Deviated septum
	Difficulty swallowing
	Dry mouth
	Ear ache
	Ear discharge
	Hearing problems
	Hoarse
	Loss of smell
	Loss of taste
	Nose bleeds
	Oral ulcer
	Post nasal drip
	Ringing in the ears
	Runny nose
	Sinus congestion
	Sinus pain/pressure
	Sleep apnea
	Sore throat
	Vertigo

Cardiovascular	
	Chest pain
	Difficulty breathing while laying down
	Heart disease
	Leg pain
	Lightheadedness
	Murmur
	Pacemaker
	Palpitations
	Passing out
	Shortness of breath on exertion
	Shortness of breath when sleeping
	Swollen ankles

Respiratory	
	Chest tightness
	Chronic bronchitis
	Cough
	Coughing up blood
	Excessive phlegm
	Shortness of breath
	Wheezing

Gastrointestinal	
	Abdominal pain
	Black or tarry stools
	Bloating
	Blood in stool
	Burping
	Change in stool
	Constipation
	Diarrhea
	Difficulty swallowing
	Excessive gas
	Gallbladder problems
	Heartburn
	Hemorrhoids
	Indigestion
	Jaundice
	Loss of appetite
	Nausea
	Vomiting

NAME: _____ DATE: _____

REVIEW OF SYSTEMS

Please select all that currently apply.

Genitourinary	
	Blood in urine
	Frequent urination
	Incontinence
	Nighttime urination
	Painful urination
	Urinary hesitancy
	Urinary urgency
	Abnormal vaginal discharge
	Endometriosis
	Low sex drive
	Menstrual irregularities
	Painful intercourse
	Pelvic pain
	Sexually transmitted diseases
	Vaginal itching/burning

****Musculoskeletal****	
	Arthritis
	Back pain
	Decreased range of motion
	Gout
	Joint pain
	Joint swelling
	Loss of strength
	Muscle cramp
	Muscle pain
	Muscle twitch
	Muscle weakness
	Stiffness
	Swelling

Skin	
	Change in nails
	Changes in skin color
	Dry skin
	Hyperpigmentation
	Hypopigmentation
	Itching
	Loss of hair
	Night sweats
	Rash
	Redness
	Skin lesions
	Skin peeling

Neurologic	
	Abnormal sensations
	Dizziness
	Headaches
	Incoordination
	Numbness
	Paralysis
	Seizures
	Tingling sensations
	Tremor

Heme/Lymphatic	
	Bleeding tendency
	Easy bruising
	Hemophilia
	Swollen lymph nodes

Allergic/Immunologic	
	Hay fever
	HIV exposure
	Hives
	Persistent infection
	Seasonal allergies

Endocrine	
	Cold intolerance
	Diabetes
	Excessive eating
	Excessive thirst
	Excessive urination
	Feeling cold
	Feeling hot
	Hair changes
	Heat intolerance
	Nervousness
	Weight change

Psychiatric	
	Agitation
	Anxiety
	Change in personality
	Compulsion
	Confusion
	Depression
	Frequent crying
	Hallucinations
	Homicidal thoughts
	Hyperactivity
	Memory loss
	Mood swings
	Panic attacks
	Paranoia
	Shortness of breath
	Sleep problems
	Suicidal thoughts

HEIGHT: _____

WEIGHT: _____

BP: _____

PATIENT SIGNATURE_____ DATE_____

PHYSICIAN SIGNATURE_____ DATE_____