Patient History Sheet

Today's Date:

Patient Name:	**Date of Birth:**	**Weight:**	**Height:**
Local Pharmacy Name (required):		**Pharmacy Address:**	
Mail Order Pharmacy (if applicable):			
What are today's complaints / symptoms?			

Please check if you HAVE EVER had any of the following:			
⚐ Anxiety	⚐ Claustrophobia	⚐ Hearing Loss	⚐ Seizure Disorder
⚐ Arthritis	⚐ COPD	⚐ Heart Attack	⚐ Sleep Apnea
⚐ Asthma	⚐ Depression	⚐ Heart Disease	⚐ Stroke
⚐ Bleeding Disorder	⚐ Diabetes	⚐ Hives	⚐ Thyroid Disease
⚐ Blood Pressure Problems	⚐ Emphysema	⚐ Kidney Problems	⚐ OTHER
⚐ Bronchitis	⚐ Glaucoma	⚐ MRSA	
⚐ Cancer (type)	⚐ Hay Fever	⚐ Psoriasis	

Medication Allergies / Food Allergies / Intolerances		
Allergy	**Reaction**	**Intolerances**
⚐ **NONE**		⚐ **Latex**
		⚐ **Adhesive**
		⚐ **OTHER:**

Family Health History	
Family Member	**Illness**
⚐ **NONE**	

Do you drink alcohol? Occasional / Moderate / Heavy	**Number of drinks per week:**
Are you a current smoker? Yes / No	**If yes, how many packs per week?**
Are you a former smoker? Yes / No **Years Smoked:**	**Second hand smoke exposure?** Yes / No

Medications / Vitamins / Supplements ⚐ **Please see attached list**		
Medication	**Strength**	**Required Dosage**
⚐ **NONE**		

Surgical History	
Surgery	**Date Performed**
⚐ **NONE**	

Please Circle ALL that apply TODAY				
General	Feeling Well	Weight Loss	Fever	Night Sweats
Skin	Bruising	Itchy Skin	Rash	
HEENT	Blurred Vision	Double Vision	Dizziness	Hearing Loss
	Ear Discharge	Ear Pain	Ringing in Ears	Seasonal Allergies
	Sinus Pain	Sore Throat	Smell / Taste Issue	
Neck	Swollen Glands			
Respiratory	Cough	Snoring	Wheezing	Bloody Sputum
Cardiovascular	Chest Pain	Leg Pain / Swelling	Shortness of Breath	
Gastrointestinal	Black Tarry Stool	Constipation	Diarrhea	Heartburn
Genitourinary	Urinary Complaints	Prostate Issues		
Musculoskeletal	Muscle Pain			
Neurological	Headaches	Weakness in arms / legs		
Hematology	Abnormal Bleeding	Easy Bruising	Nosebleeds	