Health History Form

Last Name ____________________ First Name ____________________ D.O.B
Reason for your visit today: ______________________________ Date: ____________

PLEASE LIST ALLERGIES

No Known Drug Allergies

____
____
____

CURRENT MEDICATIONS

PHARMACY NAME ____________________
PHARMACY NUMBER ____________________

Medication	Strength	Times per day taken	Prescribing MD	Reason for taking medication

PAST MEDICAL HISTORY Please list any diagnosed conditions or diseases: EXAMPLE (*diabetes, cancers, blood pressure)*

____________________ ____________________ ____________________
____________________ ____________________ ____________________

Preventive Care Check List

Please check and give dates if you have had any of the following test/vaccines:

Under 50 years of age	DATE
Annual Physical	______
Pap Smear	______
Mammogram Screening	______
Cholesterol Screening	______
Diabetes Screening	______
Tetanus Vaccine	______
Flu Vaccine	______
Dilated Eye Exam	______

50 years and older	DATE
Annual Physical	______
Pap Smear	______
Colonoscopy	______
Tetanus Vaccine	______
Shingles Vaccine	______
Flu Vaccine	______
Pneumococcal Vaccine	______
Bone Density	______
Carotid Artery Screening	______
Prostate cancer Screening	______
Mammogram	______
Dilated Eye Exam	______

PLEASE LIST SURGERIES	YEAR OF SURGERY

FAMILY HISTORY Please list any diagnosed conditions or diseases [-xample]: () iabetes ·#ancer, Blood Pressure

Please state NONE or UNKNOWN if applicable

Mother ______
Father ______
Brothers ______
Sisters ______

SOCIAL HISTORY

Married Single Widowed Divorced

Number of Children ______

Do you smoke Yes N If yes how much per day ______

Do you drink Yes N If yes how much per day ______

Do you have a history of substance of abuse? Yes N

MENTAL HEALTH HISTORY

Have you been diagnosed with any mental health problems Yes N
Such as, but not limited to:

- Bipolar
- Attention Deficit Hypertension Disorder
- Obsessive Compulsive Disorder
- Attention Deficit Disorder
- Other ______
- Schizophrenia
- Anxiety
- Anorexia
- Depression

Have you had a history of communicable diseases (STD) Yes N (Please list if yes)

______ ______
______ ______

By signing below I am stating that everything is true and accurate to the best of my knowledge

Patient or guardian signature ______ Date ______ Employee Initials ______