



New Patient Health History Form

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Pharmacy (Name/Location) \_\_\_\_\_

Reason for today's visit (please specify how long you have had these symptoms) \_\_\_\_\_

Have you had any tests, scans (CT or MRI), or treatments for this problem: Yes No

If yes, what was done and which doctor ordered them: \_\_\_\_\_

Answer all questions

1. MEDICAL HISTORY

Height \_\_\_\_\_ Weight \_\_\_\_\_

DO YOU HAVE OR HAVE YOU EVER HAD (please check box)

- Heart Disease
High Blood Pressure
High Cholesterol
Asthma
Lung Disease (specify)
Seizures, Epilepsy, Fainting or Dizziness
Bleeding Disorder, Anemia, Blood Transfusion or do you bruise easily
Liver Disease (Jaundice, Hepatitis)
Kidney Disease
Diabetes
Thyroid Disease
Stomach Ulcers or Colitis
Any disease, drug, or transplant operation that has depressed your immune system
History of Cancer: Type Treatment? When diagnosed?
Sleep/snoring problems (Please explain:)
Hearing problems
Migraines or other recurrent headaches
Do you have any other disease, condition or problem that you think the doctor should know about?
No known medical conditions

2. FAMILY HISTORY: List any Family illnesses: (heart disease, cancer, etc.)

3. SURGICAL HISTORY: Please list any surgeries/hospitalizations you have had (please include date)?

All responses are kept confidential

4. MEDICATIONS

- Do you take any aspirins, Ibuprofen, Advil, Motrin, Vitamin E, or blood thinners?
Please list all medications you take (include prescription & over-the-counter medications):

5. ALLERGIES (write 'none' if you have no known allergies)

- Please list any drug allergies
Please list any seasonal allergies or food allergies:
Have you been treated for allergies before? Y N If yes, When?
Have you had a severe reaction to allergy treatment or testing? Y N If yes, Explain:
Do you feel worse during certain times of the year? Y N What season? Winter Spring Summer Fall
What precautions do you take for perceived allergy problems? (pillow covers, air cleaners, etc.)

6. SOCIAL HISTORY:

- Do you smoke or chew Tobacco? How much per day?
Do you drink Alcohol? How much per day?
Do you have a Chemical Dependency or Emotional Disorder that may affect the care we provide you?

7. FOR WOMEN ONLY

- Are you pregnant, or is there any chance you might be pregnant?
Are you nursing?

X Patient/Guardian Signature

Print Name

Date

Date