PATIENT HISTORY FORM

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Name: ____________________
Date: ____________________
Date of Birth: ____________________
*Preferred Pharmacy: ____________________
(Include Location) ____________________

Please give thoughtful, brief answers to the following items. Write N/A for those sections not applicable.

Chief **Problem** or symptom briefly stated: ____________________

What seemed to cause or lead up to the problem? ____________________

Date started: __________ Intermittent or constant: __________
Triggered by? __________ Frequency(# of episodes)? __________

Associated body symptoms: ____________________

Treatments you've already tried & their effectiveness: ____________________

Name of doctor who referred you or who has been treating you? ____________________

Anything similar in family members or co-workers? ____________________
Family history of these symptoms? ____________________
Any habits that might have contributed to this problem? ____________________
Anything else you would like to add that you feel might help us understand this problem better?

____

Are you **ALLERGIC TO MEDICATIONS** or have you had a bad reaction to any medications, please describe: ____________________

List **CURRENT DRUGS** (blood thinners, steroids, over-the-counter medications, etc.) that you are taking: ____________________

Have you ever had or currently have:
SKIN CANCER (please specify) ☐ Basal Cell ☐ Squamous Cell ☐ Melanoma ☐ None
Please give details: ____________________

Do you **BLEED ABNORMALLY** for a long time following a cut or do you bleed easily? Please circle: **YES NO**

Does anyone in your immediate family have a bleeding disorder?
Please circle: **YES NO**

Do you have any **ADULT ILLNESS** (high blood pressure, diabetes, heart disease, etc.) please describe: ____________________

Do you smoke? Please circle: **YES NO** Do you use alcohol? **YES NO**
If yes, approx. how much: __________ Approx. how much: __________

Continued on the other side

Is there a possibility that you are pregnant? **YES** **NO**

Occupation:____

Any unusual **CHILDHOOD DISEASES**, please describe:____________________________________
____

Do you have any **ALLERGIES** such as hay fever, asthma or food allergies? Please describe:____

Please list surgical **PROCEDURES** and **HOSPITALIZATIONS** (place, date, reason):
____
____
____

FAMILY HISTORY: (please check any of the following diseases that seem to run in your family or have occurred in any related family member)

- ☐ Bleeding Disorders
- ☐ Heart disease
- ☐ Eczema
- ☐ Cancer
- ☐ Asthma
- ☐ Miscellaneous
- ☐ Skin Cancer
- ☐ Hay Fever
- ☐ Stroke
- ☐ Diabetes

SYSTEMS REVIEW: (please circle any of the following problems that you have had or currently have)

☐ Check here if none apply

- ☐ Cancer
- ☐ Diabetes
- ☐ Measles
- ☐ Mumps
- ☐ Rheumatic fever
- ☐ Epilepsy
- ☐ Pneumonia
- ☐ Asthma

- ☐ Convulsions
- ☐ Seizures or fits
- ☐ Severe headaches
- ☐ Frequent headaches
- ☐ Dizziness

- ☐ Hearing problems
- ☐ Arthritis
- ☐ Joint Pain or swelling

- ☐ Trouble swallowing
- ☐ Frequent sore throats
- ☐ Swollen neck glands
- ☐ Thyroid problems
- ☐ Hoarseness

- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Change in appetite
- ☐ Food Allergies
- ☐ Stomach trouble
- ☐ Ulcers

- ☐ Broken bones
- ☐ Chronic pain

- ☐ Nervous Breakdown
- ☐ Depression
- ☐ Anxiety
- ☐ Seen a psychiatrist

- ☐ Menstrual problems
- ☐ Abnormal vaginal bleeding
- ☐ Venereal disease
- ☐ Syphilis
- ☐ Gonorrhea

- ☐ Poor vision
- ☐ Sore that won't heal
- ☐ Ankle swelling
- ☐ Eczema
- ☐ Hay Fever

- ☐ Trouble breathing
  - ☐ During day
  - ☐ During night
  - ☐ During exercise
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Stroke
- ☐ Heart trouble
- ☐ Coughing blood
- ☐ Blood in urine
- ☐ Kidney stone
- ☐ Painful urination
- ☐ Bladder infection

- ☐ Sinus infection
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Anemia

- ☐ Gall bladder trouble
- ☐ Bowel trouble
- ☐ Liver disease
- ☐ Yellow Jaundice
- ☐ Blood in bowel movements