Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height \_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies (medications/ latex/ foods) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Provider** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR VISIT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- | --- |
| **Have you had any of the following?** | **Date** | **Have you had any of the following?** | **Date** |
| **Heart** |  | **Urinary** |  |
| Heart Attack |  | Bladder Problems |  |
| Heart disease |  | Kidney Disease |  |
| Heart Murmur |  | Kidney Stones |  |
| High Cholesterol |  | **Endocrine** |  |
| High Blood Pressure |  | Thyroid Problems |  |
| Irregular Heartbeat |  | Diabetes |  |
| Rheumatic Fever |  | **Cancer** |  |
| Stroke |  | Type: |  |
| Anemia |  | **Skin** |  |
| **Eyes Ears Nose and Throat** |  | Eczema |  |
| Cataracts |  | Psoriasis |  |
| Glaucoma |  | **Respiratory** |  |
| Hearing Loss |  | Asthma |  |
| **Gastrointestinal** |  | Bronchitis |  |
| Chrohns |  | Emphysema |  |
| Colitis |  | COPD |  |
| IBS |  | Influenza |  |
| Hepatitis |  | Pneumonia |  |
| Hernia |  | Tuberculosis (TB) |  |
| Hemorrhoids |  | Oxygen |  |
| Stomach Problems |  | **Musculoskeletal** |  |
| **Neurology** |  | Arthritis |  |
| Dizziness |  | Rheumatoid Arthritis |  |
| Seizures |  | Osteoporosis/Osteopenia |  |
| Meningitis |  | Gout |  |
| **Mental Health** |  | Multiple Sclerosis |  |
| Anxiety |  |  |  |
| Depression |  |  |  |
| **Substance Use (how much)** | | **Women Only** | |
| Smoker |  | Last Menstrual Period |  |
| Caffeine |  | Date of Last Mammogram |  |
| Alcohol |  | History of Abuse? |  |
| Drugs |  | **Men Only** | |
| **Immunizations** | | Last PSA (Blood Test) |  |
| Flu |  | Last Prostate Exam |  |
| Pneumonia |  | **Children Only** |  |
| Shingles |  | UTD on vaccinations? |  |
| Tdap or Td (Tetanus) |  | Childhood diseases? |  |
| TB (PPD)Test |  | Type: |  |
| **Injuries/Surgeries /Hospitalizations** |  | **Medications (dose/frequency)** |  |
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