NAME _____ AGE _____ TODAY'S DATE _____

PLEASE COMPLETE AND PRINT CLEARLY

********** **REASON FOR TODAY'S VISIT AND DURATION OF PROBLEM** **********

_____

_____

_____

_____

LIST ALL CURRENT MEDICATIONS AND DOSAGES INCLUDING OVER-THE-COUNTER MEDICATIONS:

_____

_____

_____

_____

PAST MEDICAL HISTORY/REVIEW OF SYMPTOMS (Circle all that apply to you as the patient)

Breast disease	Angina	Unexplained fever	HIV/AIDS
Cancer: (type_____)	Chest pain	Unexplained weight loss	Anemia
Change in smell	Heart attack	Asthma	Easy bleeding
Change in taste	Heart murmur	Bronchitis/pneumonia	Diabetes
Glaucoma	High blood pressure	Chronic cough	Hemophilia
Headaches	High cholesterol	Tuberculosis	Arthritis
Head injury	High triglycerides	Wheezing	Joint pain
Hearing loss	Palpitations	Colitis	Gout
Migraines	Poor sleep	Difficulty urinating	Herpes
Prostate disease	Seizures	Kidney disease	Lyme's disease
Ringing in ears	Stroke	Liver disease	Fatigue
Skin rashes	Stomach ulcers	Cold/heat intolerance	Other: _____

Have you fallen in the past year? Y/N

Are you pregnant: Y/N

Do you have a bleeding disorder? Y/N If yes, explain: _____

Are you taking aspirin, ibuprofen, or blood thinning products? Y/N If yes, explain: _____

PAST SURGICAL HISTORY:

List all operations you have had: _____

_____

_____

ALLERGIC HISTORY: If allergic to any of these items **(<u>especially antibiotics</u>)** circle and specify

MEDICINES ANTIBIOTICS FOODS SURGICAL TAPE LATEX NONE

SPECIFY CIRCLED ITEMS: _____

WHAT IS THE REACTION? _____

FAMILY HISTORY (Circle conditions in your blood relatives only)

Allergies	Diabetes	High blood pressure	Lung problems
Bleeding problems	Heart problems	Kidney problems	Liver problems
Cancer (type)	Hearing loss	Other _____	

SOCIAL HISTORY

Do you smoke? Yes No If yes, how many packs per day? _____ How many years_____

Do you drink? Yes No If yes, how many drinks per week? _____

***** NAME OF PRIMARY CARE PHYSICIAN** _____

***** WHO REFERRED YOU TO US?** _____

***** PHARMACY NAME / ADDRESS** _____

_____

I agree that payment for services rendered are my responsibility, and I authorize the release of any medical information Necessary to process my claims. I have received the notice of Privacy Practices.

Signature _____ **Date** _____