

Medical History

| | <u>Y</u> | <u>N</u> | | <u>Y</u> | <u>N</u> |
|---------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|
| Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Irregular Heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | Migraines | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Obesity | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Parkinson's | <input type="checkbox"/> | <input type="checkbox"/> |
| Dementia | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression | <input type="checkbox"/> | <input type="checkbox"/> | Clot in Lung | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Diverticulitis | <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea | <input type="checkbox"/> | <input type="checkbox"/> |
| Clot in Leg | <input type="checkbox"/> | <input type="checkbox"/> | Varicose Veins | <input type="checkbox"/> | <input type="checkbox"/> |
| Acid Reflux | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Mini-stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV | <input type="checkbox"/> | <input type="checkbox"/> | Trouble with anesthesia | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Circulation Problem | <input type="checkbox"/> | <input type="checkbox"/> |

Surgical History

| | <u>Y</u> | <u>N</u> | | <u>Y</u> | <u>N</u> |
|--------------------|--------------------------|--------------------------|----------------|--------------------------|--------------------------|
| Appendix | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> | Pilonidal Cyst | <input type="checkbox"/> | <input type="checkbox"/> |
| Breast | <input type="checkbox"/> | <input type="checkbox"/> | Hysterectomy | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart | <input type="checkbox"/> | <input type="checkbox"/> | Orthopedic | <input type="checkbox"/> | <input type="checkbox"/> |
| C-Section | <input type="checkbox"/> | <input type="checkbox"/> | Spinal | <input type="checkbox"/> | <input type="checkbox"/> |
| Gall Bladder | <input type="checkbox"/> | <input type="checkbox"/> | Tubal Ligation | <input type="checkbox"/> | <input type="checkbox"/> |
| Colonoscopy | <input type="checkbox"/> | <input type="checkbox"/> | Chest | <input type="checkbox"/> | <input type="checkbox"/> |
| Fractures | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach/Intestines | <input type="checkbox"/> | <input type="checkbox"/> | Tonsils | <input type="checkbox"/> | <input type="checkbox"/> |
| Hemorrhoid | <input type="checkbox"/> | <input type="checkbox"/> | Prostate | <input type="checkbox"/> | <input type="checkbox"/> |
| Hernia | <input type="checkbox"/> | <input type="checkbox"/> | Circulation | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other: | | |

List All Medications with dose, including Over-The-Counter

Allergies: _____

| | |
|--------------------------|--------------------------|
| Current Every Day Smoker | <input type="checkbox"/> |
| Current Some Day Smoker | <input type="checkbox"/> |
| Former Smoker | <input type="checkbox"/> |
| Never A Smoker | <input type="checkbox"/> |
| Unknown if Ever Smoked | <input type="checkbox"/> |

If a smoker: How Much?
 How Long?

| | <u>Y</u> | <u>N</u> | |
|---------------|--------------------------|--------------------------|-----------|
| Caffeine | <input type="checkbox"/> | <input type="checkbox"/> | How Much? |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | How Much? |
| Drugs | <input type="checkbox"/> | <input type="checkbox"/> | |
| Married | <input type="checkbox"/> | <input type="checkbox"/> | |
| Recent Travel | <input type="checkbox"/> | <input type="checkbox"/> | |
| Occupation | <input type="checkbox"/> | <input type="checkbox"/> | |

Height: _____ Weight: _____

Pharmacy Information

Name:
Location:
Phone:

NAME: _____

DOB: _____