

# Past Medical History Form

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_ DATE: \_\_\_\_\_

If something does not apply please write N/A

## Medication Allergies

Drug: Reaction:  
Drug: Reaction:  
Drug: Reaction:

## Medications (If you have a separate medication list, do not fill this out, we will copy list)

Name: Dose: Reason: Start date:  
Name: Dose: Reason: Start date:  
Name: Dose: Reason: Start date:  
Name: Dose: Reason: Start date:

## Surgical History

Procedure: Date:  
Procedure: Date:  
Procedure: Date:  
Procedure: Date:

## Medical History (Example: Diabetes, Cataracts, STD's, High Blood Pressure)

Diagnosis: Date:  
Diagnosis: Date:  
Diagnosis: Date:  
Diagnosis: Date:

## Family History

Condition/Illness: Relationship:  
Condition/Illness: Relationship:  
Condition/Illness: Relationship:  
Condition/Illness: Relationship:

## Social History

Marital Status  Married  Single  Divorced  Separated  Widowed  
Do you smoke?  Yes  Not anymore  Never smoked  
#PPD \_\_\_\_\_ When did you quit? \_\_\_\_\_  
Do you drink alcohol?  Yes  Not anymore  Never drank  
Circle- Socially, light, moderate, heavy  
How many caffeinated drinks/day?  0  1  2  3  4+  
Have you had a blood transfusion?  Yes  No

## ROS

### Constitutional:

Fever  Wt. loss  Chills

### Eyes:

Blurry vision  Double vision  Cataracts

### Ears Nose Mouth Throat:

Hearing loss  Nasal stuffiness  Sore throat

### Cardiovascular:

Chest pains  Swollen ankles  Irregular heartbeat

### Respiratory:

Shortness of breath  Wheezing  Chronic cough

### GU:

Incontinence  Painful urination  Blood in urine

### Musculoskeletal:

Chronic back pain  Chronic neck pain  Sore muscles

### Integ/skin:

Rash  Persistent skin itching  Skin cancer history

### Neurological:

Numbness  Tingling  Dizziness

### Heme/Lymph:

Swollen glands  Abnormal bleeding  Transfusion history

PHARMACY NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_