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Past Medical History Form

NAME: _____ **D.O.B.** _____ **DATE:** _____

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

Surgical History:

Procedure: _____ Date: _____
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: _____
Diagnosis: _____ Date: _____

Family History:

Condition/Illness: _____ Relationship: _____
Condition/Illness: _____ Relationship: _____
Condition/Illness: _____ Relationship: _____
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PAST MEDICAL HISTORY FORM - Continued

Social History:

Marital Status Married Single Divorced Separated Widowed

Do you smoke? Yes Not anymore Never smoked

#Packs/Day _____ When did you quit? _____

Do you drink alcohol? Yes Not anymore Never drank

Socially light moderate heavy

How many caffeinated drinks/day? 0 1 2 3 4+

Have you had a blood transfusion? Yes No

Review Of Systems:

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 _____