

**NAME** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

<b>LOCAL PHARMACY:</b>
Phone #:
<b>MAIL ORDER PHARMACY:</b>
Address:
City/ ST/Zip:
Phone #:
Member ID#:

<b>MEDICATIONS (including OTC &amp; herbs):</b>	
Name:	Mg. / Dosage

If more medications, please write on back of this form.

**ALLERGIES:** Are you allergic to any of the following? (Circle all that apply) **None** Aspirin Penicillin Codeine Metal Latex Local Anesthetics Other: \_\_\_\_\_  
 If yes, explain the associated allergic reaction: \_\_\_\_\_

**PAST MEDICAL HISTORY**

Have you been diagnosed with or had the following? (please circle): If yes, please explain below & include age of onset.

AIDS / HIV Positive	Yes No	Congenital Heart Disorder	Y No	Herpes / Cold Sores	Yes No	Scarlet Fever	Yes No
Alzheimer's Disease	Yes No	Depression	Yes No	High Cholesterol	Yes No	Shingles	Yes No
Anaphylaxis	Yes No	Diabetes	Yes No	Hypertension	Yes No	Seasonal Allergies	Yes No
Anemia	Yes No	Drug Addiction	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Angina	Yes No	Emphysema	Yes No	Irregular Heartbeat	Yes No	Sleep Apnea	Yes No
Anxiety	Yes No	Epilepsy or Seizures	Yes No	Jaundice	Yes No	Spina Bifida	Yes No
Arthritis	Yes No	Genital Herpes	Yes No	Kidney Stones	Yes No	Stroke	Yes No
Artificial Heart Valve	Yes No	Glaucoma	Yes No	Leukemia	Yes No	Thyroid Disease	Yes No
Artificial Joint	Yes No	Heart Attack	Yes No	Liver Disease	Yes No	TMJ	Yes No
Asthma	Yes No	Heart Failure	Yes No	Migraines	Yes No	Tuberculosis	Yes No
Bi Polar	Yes No	Heart Murmur	Yes No	Mitral Valve Prolapse	Yes No	Ulcers	Yes No
Blood Transfusion	Yes No	Heart Pace Maker	Yes No	Osteoporosis	Yes No	Venereal Disease	Yes No
Cancer	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No		
Chemotherapy	Yes No	Hepatitis A	Yes No	Rheumatic Fever	Yes No		
Chicken Pox	Yes No	Hepatitis B or C	Yes No	Rheumatism	Yes No		

Have you ever had any other serious illness not listed above? Yes No If yes, please explain & include dates: \_\_\_\_\_

Have you ever been hospitalized or had a major operation? YES NO If yes, please explain with type of surgery and dates: \_\_\_\_\_

**Adult Immunizations Review – Please list the Date of your Last Immunizations (write N/A if not applicable):**

Flu: \_\_\_\_\_ Pneumonia: \_\_\_\_\_ Zostavax (Shingles): \_\_\_\_\_ Tetanus/Diphtheria: \_\_\_\_\_

**SOCIAL HISTORY:**

Family / Household member (Everyone who lives in your household):

Name	Birth Year	Relationship	

Are you on a special diet? YES NO If yes, please explain: \_\_\_\_\_

Did you or do you smoke cigarettes or use other tobacco products? (please circle) YES NO Type: \_\_\_\_\_

Age started \_\_\_\_\_ Age quit \_\_\_\_\_ How many packs per day? \_\_\_\_\_

Do you use any marijuana, cocaine, or non-prescribed narcotics? (please circle) YES NO

If so, please describe: \_\_\_\_\_

How many cups of caffeinated coffee, tea, or carbonated beverage do you drink daily? \_\_\_\_\_

How many beers, mixed drinks, or glasses of wine do you have weekly? \_\_\_\_\_

Occupation: \_\_\_\_\_ How long? \_\_\_\_\_  
 Exposure to loud noises? YES / NO List: \_\_\_\_\_  
 Highest grade completed: 5 6 7 8 9 10 11 12 Trade School Comm. College 4-Yr College Advanced degree  
 Do you exercise regularly? YES / NO If so, how often? \_\_\_\_\_  
 Description of exercise/activity: \_\_\_\_\_

**FAMILY HISTORY:**

Has anyone in your immediate family had: (parents, siblings, or grandparents only)

History of:	Yes	No	If yes, family relationship(s):	Type:	Age of onset:
Alcoholism					
Allergies					
Diabetes					
Tuberculosis					
Heart Disease					
Stroke					
High Blood Pressure					
Depression / Anxiety / Bipolar					
Suicide					
Cancer					
High Cholesterol					
Thyroid issues					
Major medical problems					

**REVIEW OF SYSTEMS:**

Do you now have problems with: (Mark problems with an "X") If none of the following are complaints, please circle "None."

	Present		Present		Present
<b>1. GENERAL:</b>		<b>5. CARDIOVASCULAR:</b>		<b>8. MUSCULOSKELETAL:</b>	
* Weight loss, unplanned		* Chest Pain		* Joint Pain	
* Fatigue		* Irregular Heart Beat		* Joint Swelling	
* Memory Loss		* Elevated Blood Pressure		* Jaw Pain	
		* Heart Disease		<b>9. NEUROLOGICAL:</b>	
<b>2. HEENT:</b>		* Shortness of Breath		* Blackouts	
* Headache		* Swelling of Limbs		* Dizziness	
* Visual Loss		<b>6. GASTROINTESTINAL:</b>		* Seizures	
* Decreased Hearing		* Bloody Stool		* Stroke	
* Sinus Pain		* Constipation			
* Hoarseness		* Diarrhea			
* Sore Throat		* Heart Burn		<b>10. PSYCHIATRIC:</b>	
* Trouble Swallowing		* Jaundice		* Anxiety	
		* Kidney Stones		* Depression	
		* Nausea		* Sleep Issues	
<b>3. RESPIRATORY:</b>		* Vomiting		<b>11. ENDOCRINOLOGY:</b>	
* Cough				* Diabetes	
* Wheezing		<b>7. FEMALE / Genitourinary:</b>		* Excessive Thirst	
		* Abnormal PAP smear		* Excessive Urination	
<b>4. BREAST:</b>		* Urinary Complaints		* Libido Change	
* Breast Mass		* Blood in Urine		<b>12. HEMATOLOGY:</b>	
* Breast Pain		* Menstrual Irregularities		* Anemia	
* Skin Changes				* Bleeding Issues	

**WOMEN ONLY**

Dates of last two Periods \_\_\_\_\_  
 Current method of contraception \_\_\_\_\_  
 Are you pregnant? Yes No Are you breast feeding? Yes No  
 Are you trying to get pregnant? Yes No

Number of previous:  
 Pregnancies \_\_\_\_\_ Miscarriages \_\_\_\_\_  
 Live Births \_\_\_\_\_ Terminations \_\_\_\_\_

Age at Menopause \_\_\_\_\_  
 Date of Last: PAP Test: \_\_\_\_\_  
 Mammogram: \_\_\_\_\_  
 Dexascan: \_\_\_\_\_  
 Colonoscopy (50+): \_\_\_\_\_

**MEN ONLY**

Do you perform monthly testicular self-exams (TSE)?  
 Yes  No

Do you have a family history of prostate cancer?  
 Yes  No

Do you have symptoms of an enlarged prostate? None  
 Urinary dribbling  
 Reduced flow  
 Nighttime urination

Date of Last PSA Test: \_\_\_\_\_  
 Date of Last Colonoscopy (50+) \_\_\_\_\_