Name: _____

DOB: _____

**Primary Care Physician/Clinic:** _____

**Pharmacy and Location:** _____

**HPI**

What are you here for today? _____

_____

_____

**Past Medical History**

Have you had any of the following illnesses? (check please)

| | | | | | |
|---|---|---|---|---|---|
| Diabetes ("sugar") | | Congestive heart failure (CHF) | | Depression/Anxiety | |
| High blood pressure | | Thyroid problems | | Anemia | |
| High cholesterol | | Seizures | | Seasonal Allergies | |
| Asthma | | Headaches/Migraines | | Psoriasis | |
| COPD | | Kidney problems | | Chronic Rashes | |
| Stroke | | Liver problems | | Fibromyalgia | |
| Heart Attack | | Cancer | | Reflux (heartburn) | |

If you checked any of the above illnesses, please list the type:

_____

_____

_____

Please list any other medical conditions that you are being treated for:

_____

_____

_____

_____

**Surgical**

Please list any surgeries you have had:

_____
_____
_____

**Medications**

Please list any medicines you are currently taking. Please include strength and directions for taking:

_____
_____
_____

**Drug Allergies**

Please list any medicines that you are allergic to:

_____
_____

**Social History**

Have you ever used tobacco products (cigarettes or chewing tobacco)?

| | |
|---|---|
| | Cigarettes/cigars |
| | Chewing tobacco |
| | Used to use, but quit |
| | Never used |

If you used to smoke/chew, but quit:
How many packs/cans per day? _____
How many years did you smoke/chew? _____
When did you quit? _____

Do you drink alcohol?

| | | How much? (1-2 beers, etc) |
|---|---|---|
| | Never | |
| | Daily | |
| | Weekly | |
| | Monthly | |
| | Less than monthly | |
| | Used to drink, but quit | |

Do you use any illicit/recreational drugs?

| | |
|---|---|
| | Yes |
| | No |

If yes, what have you used?_____

_____

**Marital Status**

Please circle the appropriate answer: Married Single Divorced Separated

**Living Situation**

How many people reside in the home with you?_____

Please list them:

_____

_____

**Employment Type**

Please circle the appropriate answer: Full time Part time Retired Disabled

If employed, what is your occupation? _____

**Family History**

Please list any illnesses your family members have had:

Mother_____

Father_____

Mother's parents: Mother _____

Father _____

Father's parent: Mother_____

Father _____

Brothers _____

Sisters _____

Unknown: _____

**Review of Systems**

Please circle any symptoms that pertain to you:

**Constitutional:** fever/ chills / fatigue / weight change / night sweats / insomnia/NONE

**Eyes:** dry eyes / visual loss / blurred vision / contacts / glasses / tearing/NONE

**ENT:** dry mouth/ mouth sores / nose sores / dental pain/NONE

**Cardio:** racing heart / chest pain / chest pressure / pericarditis by history/NONE

**Pulm:** shortness of breath / wheezing / cough / painful breathing/NONE

**GI:** nausea or vomiting / diarrhea / heart burn / bloody stools / difficulty or painful swallowing/NONE

**Skin:** rashes / dry skin / scaling skin / hair loss / rashes with sun exposure / discoloration of hands with cold exposure/NONE

**Neuro:** numbness or tingling in arms and legs/ headaches/ weakness/NONE