Medical History Questionnaire

Patient Name: ___________________________ DOB: ____________ AGE: ___________

*****Please add daily medications and dosages to the *reverse side* of this form *****

Please list Allergies to MEDICATIONS/adverse reactions: __________________________
____

Pharmacy Location: _________________________________

Past Medical History (Please check all that apply)

o Aids/HIV	o Blood Clots o Easy Bleeding	o GERD/Acid Reflux o Gout	o MRSA
o Alcoholism	o Cancer (type)	o Heart Disease o Mitral Valve Prolapse	o Leukemia o Liver Disease o Lymphoma
o Alzheimer's	o COPD	o Hepatitis A B C	o Seizures
o Anemia	o Depression	o High Blood Pressure	o Stroke
o Arthritis o Rheumatoid	o Diabetes	o High Cholesterol	o Ulcers
o Asthma	o Drug Abuse	o Kidney Disease	o Vascular Disease

Please list any other conditions: ____
____

Surgical History

Surgery Intervention	Year	Surgeon

Personal Information

Tobacco	Alcohol	Recreation Drugs	Personal Information
Yes No Former	Yes No Former	Yes No Former	Height:
Amt:	Amt:	Type:	Weight:
Type:			1st Menstrual Period
Yrs Smoked:			Menopause
Yr. Quit:	Yr. Quit:		Right or Left Handed (circle)

Activities/Exercise/Sports: ____

Patient Signature: ___________________________________ Date: __________________
Or
Signature of Person Completing this Form: ____

My Medication List

Name ____ DOB ___________________

List all prescriptions, over the counter medicines, vitamins, herbs, dietary supplements, oxygen, inhalers and homeopathic remedies.

Medication Name/Date Started	Dose (mg, units, drops)	When Taken (daily, at bedtime, etc.)	Reason for Taking (blood pressure, diabetes, etc.)