

Example – Optional

PATIENT HISTORY FORM

Name: _____ Date _____

Mailing Address: _____
street city state zip

Social Security Number: _____ Phone: _____ (H) _____ (W) _____

DOB: _____ Height _____ Weight _____ HR _____ BP _____

Gender: _____ Pregnancy Status: _____

Allergies _____ Reactions _____

Devices/Alerts _____

Precription Medication History						
Name/Strength	Directions	Start Date	Stop Date	Physician	Purpose	Effectiveness

OTC Use: Check conditions for which you have used a non-prescription medication.

	Headache		Sleepiness		Rash/itching/dry skin
	Eye/ear problems		Drowsiness		Hearburn/GI upset/gas
	Cold/flu		Weight loss		Vitamins
	Allergies		Diarrhea		Herbal products
	Sinus		Hemorrhoids		Natural organic products
	Cough		Muscle/joint pain		Other _____

Over-the-Counter Medication History				
Name/Strength	Directions	Purpose	How Often	Effectiveness

Social History: Please indicate your tobacco, alcohol, caffeine and dietary habits.

Smoking History			Caffeine History	
Never smoked			Never consumed	
Packs per day for ___ yrs			Drinks per day	
Stopped ___ yrs ago			Stopped ___ yrs ago	
Alcohol History			Dietary History	
Never consumed			Number of meals per day	
Drinks per day/week			Food restrictions	
Stopped ___ yrs ago				

Medical History: Have you or any blood relative had (mark all that apply):

	self	relative		self	relative
High blood pressure			Heart disease		
Asthma			Stroke		
Cancer			Kidney disease		
Depression			Mental illness		
Lung disease			Substance abuse		
diabetes			Other _____		

Medical Problems: Have you experienced, or do you have: (circle Y or N)

Known kidney problems?	Y	N	Sores on legs or feet?	Y	N
Frequent urinary infections?	Y	N	Known blood clot problems?	Y	N
Difficulty with urination?	Y	N	Leg pain or swelling?	Y	N
Frequent urination at night?	Y	N	Unusual bleeding or bruising?	Y	N
Known liver problems/hepatitis	Y	N	Anemia?	Y	N
Trouble eating certain foods?	Y	N	Thyroid problems?	Y	N
Nausea or vomiting?	Y	N	Known hormone problems?	Y	N
Constipation or diarrhea?	Y	N	Arthritis or joint problems?	Y	N
Bloody or black bowel movements?	Y	N	Muscle cramps or weakness?	Y	N
Abdominal pain or cramps?	Y	N	Memory problems?	Y	N
Frequent heartburn/indigestion?	Y	N	Dizziness?	Y	N
Stomach ulcers in the past?	Y	N	Hearing or visual problems?	Y	N
Shortness of breath?	Y	N	Frequent headaches?	Y	N
Coughing up phlegm or blood?	Y	N	Rash or hives?	Y	N
Chest pain or tightness?	Y	N	Change in appetite?	Y	N
Fainting spells or passing out?	Y	N	Walking/balance problems?	Y	N
Thumping or racing heart?	Y	N	Other problems?	Y	N

Other Information/Comments:

Pharmacist Signature _____

Date _____