Patient Health History Forms

Please fill in or circle appropriate answer. Please complete form in its entirety.

Name: _____ Date of birth: _____/_____/_____

Home Phone #:_____-_____-_____ Cell phone #: _____-_____-_____

Main phone # to reach you: _____Email:_____

Local pharmacy: Phone # _____-_____-_____ Name & location: _____

Mail-order pharmacy: phone # _____-_____-_____ Name & location: _____

Doctors list: name, phone number, and specialty.

Specialty	Full Name	Phone Number & Address
Primary doctor/Internist		
Heart doctor/Cardiologist		
Diabetes doctor/Endocrinologist		
Hematologist/Oncologist		
Rheumatologist		
Other:		
Other:		
Other:		

Medical History: Please circle or write in any medical conditions.

High blood pressure:	yes or no	**Stroke/TIA**:	yes or no
Diabetes:	yes or no	**Kidney stones**:	yes or no
Chronic kidney disease:	yes or no	**Congestive heart failure**:	yes or no
Heart disease:	yes or no	**Heart attack**:	yes or no
List any other medical conditions:			

Do you use any of the following? (Circle): Tylenol Motrin ibuprofen Aleve acetaminophen naproxen

Drug allergies:_____NO drug allergies

Medications: Name, dose/MG/strength, and when taken.

Name	Dose/MG/strength	Taken when: AM, PM, etc.

Social History: Fill in or circle correct answer.

Do you smoke? No If Yes: (type)_____Number of years used:_____Quit (year)_____

Do you live: Alone with others (who?)_____

Occupation:_____Retired

Do you drink alcohol? No If Yes: (type)_____Number of years used:_____Quit (year) ____

Number of drinks per week?_____

Illicit/Recreational drug use: Yes No

Family History: Please list any medical issues. DO NOT WRITE NAMES OF FAMILY.

Mother (List any medical problems):_____ Deceased age: _____

Father (List any medical problems):_____ Deceased age: _____

Family history of the following: write who next to disease.

Kidney Disease:	Yes or No	**Hypertension:**	Yes or No
Cancer:	Yes or No	**Coronary Artery Disease:**	Yes or No

Vaccine History: Please list any recent vaccines and dates received.

Name	Date

Surgical History: List any surgeries or major procedures and the date it occurred.

Surgery/procedure name	Date

Current symptoms: Please check any problems below that you experience currently.

☐ Fever/chills	☐ Persistent Cough	☐ Diarrhea	☐ Frequent Urination	☐ Straining to Urinate	☐ Bone or Joint Pain
☐ Night Sweats	☐ Wheezing	☐ Blood in Urine	☐ Up at night to urinate often	☐ Excess Urination	☐ Headaches
☐ Blurry Vision	☐ Nausea	☐ Kidney Stones	☐ Foamy Urine	☐ Leaky Bladder	☐ Dizziness or Vertigo
☐ Nosebleeds	☐ Vomiting	☐ Burning with Urination	☐ Weak Urine Stream	☐ Muscle pain or weakness	☐ Balance Problems
☐ Sinus Problems	☐ Irregular Heart Rate	☐ Swelling in hands or feet	☐ Shortness of breath	☐ Leg pain or cramps	☐ Constipation
☐ Chest Pain	☐ Abdominal Pain	☐ Confusion	☐ Excessive Thirst	☐ Chronic Fatigue	☐ Back Pain