MR#

PAST MEDICAL HISTORY

HOSPITALIZATIONS: (REASON/DATE)
_____
_____
_____
_____
_____
_____

SURGERY: (*circle all that apply)*
APPENDIX ● GALLBLADDER ● HYST ●
HEART ● COLON ● BOWEL ● BACK
GASTRIC BY-PASS ● THYROID ● TUBAL LIGATION
OTHER:_____
_____
_____

IMMUNIZATIONS: (Indicate year of last dose)
Tetanus_____ Influenza_____
Pneumonia_____

TOBACCO: (*circle all that apply)*
Currently Smoke Never Smoked Dip Chew
Quit Smoking(date_____) Smoke___packs/day

ALCOHOL: (*circle all that apply)* Never Social Daily Light Moderate Heavy

ALLERGIES TO MEDICATION: NONE
_____
_____
_____
OTHER ALLERGIES: (ie, food, pollen, bee stings)_____

PRESENT MEDICATIONS; NONE (Name and Dose)_____
_____
_____
_____

PRIMARY CARE PROVIDER:_____ OTHER MD'S:_____
_____

FAMILY HISTORY: (If any blood relative has suffered from the following? - Please indicate which relative)
Hypertension_____
Diabetes_____
Epilepsy/Seizure_____
Arthritis_____
Stroke/CVA_____
Mental Illness_____
COPD_____
Heart Disease_____
Cancer_____
Thyroid_____
Migraines_____
Tuberculosis_____
Asthma_____
Other:_____

MEDICAL HISTORY: (Have you ever had any of the following? √ Y for "yes" N for "no". **PLEASE ANSWER EVERY QUESTION)**

ILLNESS	Y	N		Y	N		Y	N
ASTHMA			ARTHRITIS			ALCOHOL ABUSE		
ANEMIA			BACK PROBLEMS			BIPOLAR DISORDER		
BLEEDING DISORDER			BRONCHITIS			BONE FRACTURE		
CANCER			↑CHOLESTEROL			CONGESTIVE HEART FAILURE		
CROHNS			DEPRESSION/ANXIETY			DIABETES		
DIVERTICULOSIS			DRUG ADDICTION			ECZEMA/PSORIASIS		
EMPHYSEMA			FIBROMYALGIA			GERD (REFLUX)		
GLAUCOMA			GOUT			HEAD INJURY		
HEART ATTACK (MI)			HEPATITIS			HIV/AIDS		
HIGH BLOOD PRESSURE			IBS			KIDNEY DISEASE/STONES		
LIVER DISEASE			MIGRAINE HEADACHES			PANCREATITIS		
STD(sexually transmitted disease)			STROKE (CVA)			THYROID DISORDER		
TUBERCULOSIS			SLE (Lupus)					

_____ _____ _____ _____
Patient or Guardian Signature & Relationship to Patient Today's Date Review Date Review Date

_____ PHARMACY:_____
PATIENT NAME ADDRESS:_____

Rev: 10/07/2013