_______________ __/__/__
PATIENT NAME BIRTHDATE

**PRIMARY CARE PHYSICIAN** ________________________________________________
NAME PHONE NUMBER

**ADDRESS** ________________________________________________
STREET SUITE CITY STATE ZIP

**PREFERRED PHARMACY** ________________________________________
NAME PHONE NUMBER

**ADDRESS** ________________________________________________
STREET CITY STATE ZIP

**REASON FOR TODAY'S VISIT** ______________________________________

## CURRENT MEDICATIONS: (*INCLUDE VITAMINS, SUPPLEMENTS, AND OVER THE COUNTER MEDICATIONS*)

☐ **NO CURRENT MEDICATIONS**

| DRUG NAME & DOSAGE | DRUG NAME & DOSAGE |
|---|---|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

## MEDICATION ALLERGIES: (*IF YES, COMPLETE BELOW*) ☐ NO KNOWN MEDICATION ALLERGIES

| NAME OF DRUG | TYPE OF REACTION |
|---|---|
| | ☐ RASH ☐ DIFFICULTY BREATHING ☐ STOMACH PAIN/VOMITING ☐ OTHER |
| | ☐ RASH ☐ DIFFICULTY BREATHING ☐ STOMACH PAIN/VOMITING ☐ OTHER |
| | ☐ RASH ☐ DIFFICULTY BREATHING ☐ STOMACH PAIN/VOMITING ☐ OTHER |

**DO YOU HAVE NOW, OR HAVE YOU EVER HAD DISEASES OR CONDITIONS OF: (*PLEASE CHECK YES OR NO*)**

| LUNGS: | YES | NO |
|---|---|---|
| BRONCHITIS | ☐ | ☐ |
| ASTHMA | ☐ | ☐ |
| CHRONIC COUGH | ☐ | ☐ |
| MORNING COUGH | ☐ | ☐ |
| SHORTNESS OF BREATH | ☐ | ☐ |
| WHEEZING | ☐ | ☐ |
| CARDIOVASCULAR: | | |
| HIGH BLOOD PRESSURE | ☐ | ☐ |
| CHEST PAIN | ☐ | ☐ |
| HEART ATTACK | ☐ | ☐ |
| HEART MURMUR | ☐ | ☐ |
| IRREGULAR HEARTBEAT | ☐ | ☐ |
| BLOOD CLOTS | ☐ | ☐ |
| DEPRESSION | ☐ | ☐ |

| GASTROINTESTINAL: | YES | NO |
|---|---|---|
| DIABETES | ☐ | ☐ |
| THYROID | ☐ | ☐ |
| KIDNEY | ☐ | ☐ |
| BLADDER | ☐ | ☐ |
| STOMACH ABSORPTIVE DISORDER | ☐ | ☐ |
| NAUSEA, VOMITING, DIARRHEA | ☐ | ☐ |
| OTHER: | | |
| YEAST INFECTIONS FROM ANTIBIOTICS | ☐ | ☐ |
| ARTHRITIS/JOINT DEFORMITY | ☐ | ☐ |
| LIMITED JOINT MOBILITY | ☐ | ☐ |
| ARTIFICIAL JOINT | ☐ | ☐ |
| CONVULSIONS, EPILEPSY OR SEIZURES | ☐ | ☐ |
| FAINTING | ☐ | ☐ |
| SEASONAL ALLERGIES/HAY FEVER | ☐ | ☐ |

**LIST ANY OTHER DISEASE OR CONDITIONS:** ________________________________

**LIST ANY SURGERIES IN THE LAST 6 MONTHS:** ________________________________

_________________________ ___/___/____
**PATIENT NAME** **BIRTHDATE**

**SKIN:**

HAVE YOU EVER HAD SKIN CANCER: ☐ YES ☐ NO
HAS ANYONE IN YOUR FAMILY HAD SKIN CANCER? ☐ YES ☐ NO
DO YOU HAVE A HISTORY OF ANY SPECIFIC SKIN CANCER? ☐ YES ☐ NO
DO YOU HAVE PROBLEMS HEALING? ☐ YES ☐ NO
HAVE YOU EVER DEVELOPED A KELOID (THICKENED SCAR AFTER SURGERY? ☐ YES ☐ NO
DO YOU BLEED EASILY? ☐ YES ☐ NO

**ARE THERE ANY DISEASES OR MEDICAL CONDITIONS THAT RUN IN YOUR FAMILY?** ______________________

______________________________________________________________________________________________

**SOCIAL HISTORY:**

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, HOW MANY DRINKS PER WEEK: ________
DO YOU USE IV DRUGS? ☐ YES ☐ NO IF YES, WHAT? ________________ HOW OFTEN? ___________
**SMOKING STATUS** ***(Check one)*** **☐ NEVER BEEN A SMOKER ☐ FORMER SMOKER**
**☐ CURRENT SOMETIME SMOKER ☐ CURRENT EVERYDAY SMOKER**

DO YOU HAVE, OR HAVE YOU BEEN EXPOSED TO HIV (AIDS)? ☐ YES ☐ NO
DO YOU HAVE CHRONIC HEPATITIS B OR C? ☐ YES ☐ NO

WHAT IS YOUR OCCUPATION? ______________________________________________________________________

HOBBIES: ______________________________________________________________________________

**(WOMEN) ARE YOU, OR THERE A CHANCE THAT YOU MIGHT BE, PREGNANT: ☐YES ☐NO DUE DATE ________**

*Please indicate which of the following methods of contacting you that we are authorized to use if we need to report lab test results or remind you of your appointment.*

**PHONE:** ____________________________ **MAY WE LEAVE A MESSAGE? ☐ YES ☐ NO**

**MAIL: ☐ YES ☐ NO**

*IF YES, PLEASE GIVE US THE ADDRESS YOU PREFER:*

TO_________________________________________

STREET ADDRESS __________________________________________

CITY, STATE _____________________________________ ZIP _______________

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PLEASE SIGN BELOW TO CONFIRM THAT THE INFORMATION IS CORRECT TO THE BEST OF YOUR KNOWLEDGE

_____________________________________ _____/_____/_____
SIGNATURE DATE

**THE ABOVE MEDICAL HISTORY AND REVIEW OF SYMPTOMS HAVE BEEN RECEIVED ________(MEDICAL STAFF TO INITIAL)**