PAST HISTORY

HEIGHT: ______________ WEIGHT: ______________ DATE OF BIRTH: ____/____/____

CHIEF COMPLAINT: ____

LIST OF ALL ALLERGIES, INCLUDING MEDICATIONS. IF NO ALLERGIES, SIMPLY STATE NONE: ______________

____

LIST OF CURRENT MEDICATIONS, INCLUDING OVER THE COUNTER MEDICATIONS: ______________

____

____

____

PLEASE CHECK THE BOX BELOW IF YOU HAVE HISTORY OF THE FOLLOWING:

ANEMIA ☐YES
ANXIETY ☐YES
ARTHRITIS ☐YES
ASTHMA ☐YES
CATARACTS ☐YES
CHF ☐YES
CLOTTING DISORDER ☐YES
COPD ☐YES
DEPRESSION ☐YES
DIABETES MELLITUS ☐YES

EMPHYSEMA ☐YES
GERD ☐YES
GLAUCOMA ☐YES
GOITER ☐YES
HEART MURMUR ☐YES
CHICKEN POX ☐YES
HIV/AIDS ☐YES
HYPERLIPIDEMIA ☐YES
HYPERTENSION ☐YES
HYPERTHYROIDISM ☐YES

KIDNEY DISEASE ☐YES
MENINGITIS ☐YES
HEART ATTACK ☐YES
NERVE/MUSCLE DISEASE ☐YES
OSTEOPOROSIS ☐YES
SICKLE CELL ANEMIA ☐YES
STROKE ☐YES
SUBSTANCE ABUSE ☐YES
THYROID DISEASE ☐YES
TUBERCULOSIS ☐YES

PLEASE LIST ANY OTHER MEDICAL CONDITIONS NOT LISTED ABOVE: ______________

____

PLEASE LIST ANY SURGERIES THAT YOU HAVE HAD IN THE PAST: ______________

____

____

____

DO YOU HAVE A HISTORY OF CANCER? ☐YES ☐NO IF YES WHAT TYPE: ______________

____

DO YOU HAVE A FAMILY HISTORY OF CANCER? ☐YES ☐NO IF YES WHO AND WHAT TYPE: ______________

____

ARE YOU A ☐CURRENT ☐FORMER SMOKER ☐NEVER A SMOKER? HOW MANY YEARS HAVE YOU SMOKED? ______
HOW MANY PACKS PER DAY? ______________ WHEN DID YOU QUIT? ______________

PREFERRED LOCAL PHARMACY (NAME/STREET/CITY): ______________
PREFERRED MAIL ORDER PHARMACY: ______________
PREFERRED LAB: ______________