HEALTH HISTORY

Date: ____________

Name: ____________ DOB: ____________ Age: ____________

Occupation: ____________ Employer: ____________

1. **What is your health concern today?** ____________
2. **Medication Allergies:** ____________
3. **Last Menstrual Period:** ____________ **Are you currently pregnant?** ____________
4. **Who is your primary care physician?** ____________
5. **Which pharmacy would you like to use today?** (city and road please) ____________

6. **Medications** – Please list the name and dosage of all medications, supplements and non-prescription medications.

Medication	Dosage	Medication	Dosage

7. **Personal History** – Please check all that apply to ***YOU.***

Allergies	Asthma	Diabetes	High Cholesterol	Seizures
Anemia	Cancer	Glaucoma	Hypertension	Stomach Problems
Anxiety	Clotting Disorder	Headaches	Kidney problems	Stroke:
Arthritis	Depression	Heart Disease	Liver Problems	Other:

8. **Hospitalizations or Surgeries –**

Reason:	Year:	Reason:	Year:

9. **Family History** – Please check all that apply to ***YOUR FAMILY***.

	Mother	Father	Sister	Brother	Grandmother Mother's Side	Grandmother Father's Side	Grandfather Mother's Side	Grandfather Father's Side
Allergies								
Anemia								
Anxiety								
Arthritis								
Asthma								
Cancer								
Clotting Disorder								
Depression								
Diabetes								
Glaucoma								
Headaches								
Heart Disease								
High Cholesterol								
Hypertension								
Kidney Problems								
Liver Problems								
Seizures								
Stomach Problems								
Stroke								

10. **Habits -**

Alcohol	Y/N	# drinks/week:	**Smoking**	Y/N	# cig/day	
Caffeine	Y/N	# cups/day:	**Exercise**	Y/N	# times/week	Type: