Medical Information

Date _____ Referred by _____

Name _____ DOB _____/_____/_____

Medical Conditions **(Circle All That Apply)** **None**

Diabetes	Arthritis	**Hepatitis**
High Blood Pressure	Thyroid Disorders	**Restless Legs**
Heart Condition	Heart Arrhythmia	**Other:**
Stroke	Cancer	
Asthma	Emphysema	
Stomach Ulcers	Shingles	
Kidney Stones	HIV/AIDS/ARC	

Current Medications / None	**Dose**	**Frequency**

List Your Pharmacy of Choice

Pharmacy: _____

Tele. # (_____) _____ Fax # (_____) _____

Address: _____

Any Family History Of (Circle All That Apply)

Cancer (If so, what type of cancer)_____

Diabetes (If so, what type)_____

High Blood Pressure Heart Disease

Other: _____

Social History

	Yes	No	
Smoke:	☐	☐	Quantity _____
Drink Alcohol:	☐	☐	Consumption _____
IV Drug Use:	☐	☐	

Occupation : _____

Allergies to Medications **None**

Hospitalizations / Operations **None**

Review of Systems:	No	Yes	**IF yes, Please Explain**
Chronic fever, unexpected weight loss/gain fatigue?.....	☐	☐	
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)……	☐	☐	
Heart problems (e.g., chest pain, irregular heart beat)……	☐	☐	
Respiratory problems (e.g., shortness of breath, wheezing, coughing……	☐	☐	
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, nausea)……	☐	☐	
Urinary problems (e.g., pain or discomfort, blood in urine)…..……..	☐	☐	
Skin problems (e.g., rashes, ulcers)……..……..	☐	☐	
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)……	☐	☐	
Neurologic problems (e.g. numbness, weakness, new headaches, imbalance)…….	☐	☐	
Psychiatric problems (e.g., depression, new anxiety)……..	☐	☐	
Hematologic/lymphatic problems (e.g., bleed easily, lymph node swelling)……	☐	☐	