Today's date: _____

Patient Name: _____Birthdate_____

Pharmacy: _____ Pharmacy Address: _____

Consent to obtain electronic medication list from your pharmacy: ☐ Yes ☐ No

Address: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____Cell phone: _____

Preferred way to be contact: ☐ Home ☐ Cell ☐ Email: _____

Emergency contact: _____ relationship to you: _____ Phone: _____

Referring doctor: _____ Primary doctor: _____

Employed ☐ Retired ☐ Student ☐ Not working ☐ Married ☐ Single ☐

Divorced ☐ Widowed ☐ Have you received a flu vaccine? ☐ Yes ☐ No Date: _____

Pneumococcal vaccine (pneumonia/ meningitis)? ☐ Yes ☐ No

Surgical history

DATE	DESCRIPTION OF SURGERY	DATE	DESCRIPTION OF SURGERY

Medications (Please list ALL current medication including vitamins)

Are you taking Aspirin? ☐ Yes ☐ No Circle one: 81 mg or 325 mg Other dose: _____

Are you taking a blood thinner? ☐ Yes ☐ No Drug name: _____ strength: _____

Are you taking a cholesterol medication? ☐ Yes ☐ No Drug name: _____ strength: _____

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

Any medication reactions or allergies? ☐ **No known Drug allergies**

Medication	Reaction

Family medical history (please circle all that apply and the person who has it in your immediate family)

	Condition	Relationship to you		Condition	Relationship to you
Yes No	Aneurysm		Yes No	High cholesterol	
Yes No	Blood clots		Yes No	Mental illness	
Yes No	Cancer		Yes No	Peripheral vascular disease	
Yes No	Diabetes		Yes No	Stroke	
Yes No	Heart disease		Yes No	Skin ulcers	
Yes No	Heart attack		Yes No	Varicose veins	
Yes No	High blood pressure		Other family conditions:		

Social history

Tobacco use:
☐ Never ☐ Rarely ☐ Daily (packs per day) _____ total years _____ ☐ Smokeless tobacco

☐ Prior smoker Total number of years smoked _____ Packs per day _____

Alcohol use:
☐ Never ☐ Rarely how often?: _____ type: _____ ☐ Daily (glass/day) _____ type: _____

Drug use: ☐ No ☐ Yes type: _____

Medical history (Check all that apply)

Abdominal pain	☐	Headaches	☐	Pain in arms	☐
Aneurysm	☐	Hearing loss	☐	Pain in legs	☐
Arthritis	☐	Heart attack	☐	Pain when walking	☐
Asthma	☐	Heart burn	☐	Peripheral vascular disease	☐
Back pain	☐	Hepatitis	☐	Phlebitis	☐
Blood clots	☐	High blood pressure	☐	Pulmonary disease	☐
Cancer	☐	High cholesterol	☐	Pulmonary embolus	☐
Chest pain	☐	HIV/AIDS	☐	Restless leg syndrome	☐
Constipation	☐	Incontinence	☐	Shortness of breath	☐
Depression	☐	Joint pain	☐	Skin rashes	☐
Diabetes	☐	Kidney disease	☐	Skin ulcers	☐
Dialysis (PD/Hemo)	☐	Kidney stones	☐	Sexually transmitted disease	☐
Difficulty sleeping	☐	Muscle pain	☐	Stroke	☐
Dizziness	☐	Nausea	☐	Swelling in legs	☐
Emphysema	☐	Neck pain	☐	Tuberculosis	☐
Frequent urination	☐	Neuropathy	☐	Varicose veins	☐
Glaucoma	☐	Osteoporosis	☐	Weakness in arms	☐
Gout	☐	Pace maker	☐	Weakness in legs	☐