History Update: Please let us know of any changes in the following areas since last year:

(New patients- Please fill out completely)

Name_____ Age_____ Preferred Contact: __ Home Phone, __Cell Phone

Marital Status: (Circle) Married Divorced Single Widowed Legally Separated Other

Pharmacy Name:_____Intersection or Phone Number:_____

Smoking History: (Circle ONE) Never Smoked Former Smoker, Quit Date_____ Current Daily Smoker
Occasional Smoker

Family Medical History: CIRCLE any positives and put approximate age of onset

Mother: Alive, age ___ Died, age ___ , Hypertension __ High Cholesterol __ Diabetes__ Heart Attack __
Coronary Disease __ Stroke __ Alzheimer's__ Depression __ Cancer__ Type_____
Thyroid Problems__ Tobacco use: Yes No Other Problems_____

Father: Alive, age ___ Died, age ___ , Hypertension __ High Cholesterol __ Diabetes__ Heart Attack __
Coronary Disease __ Stroke __ Alzheimer's__ Depression __ Cancer__ Type_____
Thyroid Problems__ Tobacco use: Yes No Other Problems_____

Health Problems In the Family?*

***Maternal Grandparents_____**

***Paternal Grandparents_____**

***Aunt/Uncles_____**

***Brothers/Sisters_____**

Any Drug allergies? Please list the type of reaction also:_____

Please list names and dosages of all PRESCRIPTION drugs you take:

_____

_____

_____

Please list all SUPPLEMENTS and over the counter drugs you take:

_____

Have you had any of the following? If so, when?

Colonoscopy _____Eye Exam_____ Tetanus_____TDap_____ Pneumonia Vaccine_____ Flu Shot_____
Zostavax____ Hep B Series_____Hep A Series_____ Gardasil Series_____ Hepatitis C Screening _____

Women Only: Mammogram_____ Pap Smear_____ Bone Density_____

Number of Pregnancies____ Number of Live Births_____ Menopausal? _____

Since your last yearly check-up have you had any hospitalizations, serious illness, or surgeries?

_____

_____

Please circle/ comment if you are experiencing any of the following symptoms recently:

Fatigue_____

Weight Loss or Gain_____

Headache_____

Dizziness/Light Headed_____

Vision Changes_____

Depression/Anxiety_____

Insomnia_____

Daytime Sleepiness_____

Substance Abuse Concern_____

Allergy Symptoms_____

Chest Pains/Palpitations_____

Shortness of Breath or Wheeze_____

Cough_____

Heart Burn_____

Gas/Bloating_____

Diarrhea/ Constipation_____

Urinary Symptoms_____

Sexual Problems_____

Back or Neck Ache_____

Joint Ache _____

Edema/ Swelling at ankles_____

Numbness/Burning_____

Any other concerns about your health?_____

_____

_____

Describe your current exercise level and frequency_____

Describe alcohol use: None____ Rare____ Socially/Occasionally ____ Daily___ (Amount/Type)_____

If there a history of prior abuse of alcohol abuse, how many years sober?_____

Any dietary questions/ concerns/ problems you are having?_____

_____

(Office use): BP_____HR_____R_____T_____ Ht _____ Wt_____

_____

_____

_____