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# PATIENT MEDICAL HISTORY

**Patient Name:** ______________________________ **Age:** ____________

**Primary Care Physician:** ______________________

**Usual Pharmacy:** ____________________________ **Pharmacy Address:** _______________________

**Reason for Visit:** __________________________________________________________________________

| **HEALTH CONDITIONS/ ILLNESSES** | **MEDICATIONS (List with dosing, if known)** | **SURGERIES (Please list with dates)** |
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| | | |
| | | |
| | | |
| | ☐ See Attached List | |
| **ALLERGIES (Please list)** | **TOBACCO USE (List packs per day)** | **BLEEDING PROBLEMS (If yes, please explain)** |
| | Smoke: | |
| | Chew: | |
| | Quit Date: | |

## <u>REVIEW OF SYSTEMS</u>:

Please check all **current** symptoms

| | | | | | |
|---|---|---|---|---|---|
| **General:** | ☐ Weight Loss | ☐ Weight Gain | ☐ Weakness | ☐ Fever | ☐ None |
| **Eyes:** | ☐ Visual Loss | ☐ Double Vision | ☐ Blurry Vision | ☐ Eye Pain | ☐ None |
| **Ears:** | ☐ Hearing Loss | ☐ Ringing | ☐ Ear Drainage | ☐ Ear Pain | ☐ None |
| **Nose:** | ☐ Nasal Congestion | ☐ Nasal Drainage | ☐ Allergies | | ☐ None |
| **Throat:** | ☐ Swallowing Problems | ☐ Hoarseness | ☐ Throat Pain | | ☐ None |
| **Cardiovascular:** | ☐Chest Pain | ☐ Palpitations | ☐ High Blood Pressure | | ☐ None |
| **Respiratory:** | ☐ Asthma | ☐ Cough | ☐ Shortness of Breath | | ☐ None |
| **Gastrointestinal:** | ☐ Acid Reflux | ☐ Heart Burn | ☐ Ulcers | | ☐ None |
| **Musculoskeletal:** | ☐ Arthritis | ☐ Muscle Aches | | | ☐ None |
| **Skin:** | ☐ Lesions | ☐ Dryness | ☐ Itching | | ☐ None |
| **Neurologic:** | ☐ Dizziness | ☐ Headache | | | ☐ None |
| **Psychiatric:** | ☐ Depression | ☐ Other (please list): | | | ☐ None |
| **Endocrine:** | ☐ Diabetes | ☐ Thyroid Disease | | | ☐ None |