



## MEDICAL HISTORY / MEDICATION SHEET

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

### Pharmacy Information:

Check which pharmacy refills should be sent to:

Local Pharmacy Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Mail Order Pharmacy Name: \_\_\_\_\_

Primary Care Physician Name & Phone #: \_\_\_\_\_

Please list all medications, vitamins, herbal supplements and any other over-the-counter medication you are taking with the strength and directions of each. (PLEASE LIST EVERY PILL YOU TAKE)

MEDICATIONS / VITAMINS	STRENGTH (Ex. 50 mg)	DIRECTIONS (Times a day)	MEDICATIONS / VITAMINS	STRENGTH (Ex. 50 mg)	DIRECTIONS (Times a day)

Allergies: \_\_\_\_\_

### Past Medical History:

Please summarize your medical history. Indicate if you have had diabetes, hypertension, high cholesterol, cancer, thyroid, pulmonary, neurologic disease, kidney disease, gastroenterologic disease, etc. Note the approximate onset in months/years.

### Family History:

Please summarize illnesses that your family members (parents, brothers/sisters, etc.) have or have had. Include age at time of onset of illness and age at time of death (ex. Heart attack at 56 and died of heart failure at 60. He also had diabetes and high blood pressure. He was a heavy smoker)

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brothers/Sisters: \_\_\_\_\_

Other: \_\_\_\_\_

### Social History:

Do you or have you ever smoked or used any other tobacco products?  Yes:  No How much per day/week? \_\_\_\_\_

Do you consume alcohol?  Yes:  No How much per day/week? \_\_\_\_\_

Past Surgical History: Please indicate type of surgery, date and why it was done (ex. Hysterectomy at 45 for fibroids)

How did you hear about our practice? \_\_\_\_\_

Primary Care Physician (address and phone number): \_\_\_\_\_