Pharmacy and Medication Information

Name:_____ **Date of Birth:**_____

Local Pharmacy (Name and Number)_____

Mail Order Pharmacy Name and Number_____

ALLERGIES:

No Known Allergy _____

List Allergy and Reaction

_____

_____

MEDICATIONS: (Including vitamins and Over-the-Counter Medications)

I take the following medications:

Medication Name Doseage How many pills and how often

_____

_____

_____

_____

_____

_____

_____

_____

Please list the names and phone numbers for your other physicians:

Name_____ Speciality_____ Phone_____

Name_____ Speciality_____ Phone_____

Name_____ Speciality_____ Phone_____

Name:_____Date of Birth:_____

Adult History

Past Medical History (Check if appropriate)

Allergies_____Blood Clots_____Gallbladder Disease_____Heart Attack_____

Anemia_____Cancer_____Gerd (Reflux)_____Osteoarthritis_____

Angina_____ CVA_____ Hepatitis C_____Osteoporosis_____

Anxiety_____COPD_____High Cholesterol_____ Ulcers_____

Arthritis_____Heart Disease_____ High Blood Pressure_____ Kidney Disease_____

Asthma_____Crohn's Disease____ Irritable Bowel_____ Seizure Disorder_____

Atrial Fibrillation_____Depression_____ Liver Disease_____ Thyroid Disease_____

BPH Large Prostate____Diabetes _____Migraine Headache_____ STD_____

Stroke/TIA_____Heart Attack_____Colon Polup _____Dementia_____

Family History of the above mentioned conditions (Mother, Father, Sister, Brother, Grandparents:

_____
_____
_____
_____
_____

Past Surgical History (List all Surgical Procedures and Dates)

_____
_____
_____
_____
_____

List last date of:

Colonoscopy_____ Mammogram_____Pap_____

Last Menstral Cycle _____

Name:_____Date of Birth:_____

Social History

Primary Language Spoken_____Occupation_____

Tobacco Use? Yes_____ No_____ If Yes, what type_____
#Pks/Cans per day_____# of Years_____

Former Smoker – Type _____Year Quit_____#Pks/Cans Per Day_____
Years_____

Alcohol Use? Yes _____No_____ Type:_____Frequency_____
Amount_____

Former Alcohol Use – Yes_____Year Quit_____

Caffeine Intake? Yes_____No_____Type_____Amount Per Day_____

Activity Level: Sedentary_____Moderate_____Vigorous_____

Drug Use? Yes_____No_____Former_____Year Quit_____
(Drugs of Choice)_____

Sexually Active? Yes_____No_____Previously_____
Do you use condoms? Yes_____No_____
Method of Contraception?_____
Menopause_____
If Female, Gynecologist's Name_____
Phone #_____

Advance Directives

Do you have an Advance Directive in place? Yes_____No_____(Please provide a copy for our office)
On your Advance Directive or Living Will, have you chosen "Do Not Resuscitate"?
Yes_____No_____
Do you have a Durable Power of Attorney for Health Care? Yes_____No_____
Do you have a Health Care Proxy? Yes_____No_____
Do you have a Living Will? Yes_____No_____

Patient/Legal Guardian
Signature_____Date_____
Legal Guardian Printed Name_____Relationship_____