***Patient Health Information Form***

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| --- |
| **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Pharmacy** (***name and number***)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| (All new prescriptions and refills will be submitted electronically to your designated pharmacy) |

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| What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Were you born between 1946 and 1964**?\_\_\_\_\_\_\_\_\_**Have you been tested for Hepatitis C**?\_\_\_\_\_\_ |

***Medical History:*** (Please circle all that apply)

Heart Disease Stroke High blood pressure Diabetes

High Cholesterol Asthma COPD Seizure

Thyroid problems Liver disease Hepatitis C Hepatitis B

Acid Reflux Irritable Bowel Back pain Fibromyalgia

Migraines Anxiety Depression Crohn’s

Ulcerative Colitis Kidney disease Cancer (list type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***In general do you have any of the following symptoms?*  (Circle all that apply)**

Trouble swallowing Hoarseness Constipation

Always Tired Rectal Bleeding Rectal Pain

Loss of appetite Sore throat Diarrhea

Weight loss/gain Cough Black/tarry stools

Shortness of breath Hemorrhoids Heartburn/acid reflux

Hepatitis Loose stools Abdominal pain

Nausea Colon cancer Abdominal bloating

Ulcers Chest pain Pelvic pain

Falls/stumbling Vomiting/dry heaves Recent imaging/labwork

**Past Surgical History**:

Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recent Hospitalizations/REASON**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**: (Check all that apply) parents alive or deceased

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Colon cancer | Other cancer | Hypertension | Heart Disease | Liver Disease | Abnormal Cholesterol | diabetes | Thyroid Problems |
| Mother  |  |  |  |  |  |  |  |  |
| Father |  |  |  |  |  |  |  |  |
| Brother |  |  |  |  |  |  |  |  |
| Sister |  |  |  |  |  |  |  |  |
| Son |  |  |  |  |  |  |  |  |
| Daughter |  |  |  |  |  |  |  |  |
| Grandparents |  |  |  |  |  |  |  |  |

***Medications:*** (List all prescription and over the counter medications that you are currently taking)

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| --- | --- | --- | --- |
| Medication | Reason for taking |  Dosage |  Directions |
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|  |  |  |  |
| Do you take aspirin? Yes/NO |  |  |  |

**Allergies**: (circle all that apply)

Sulfa Penicillin Statins (cholesterol medication) Codeine

Latex Other allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**: (Check all that apply)

Tobacco Use: None\_\_\_\_ 1pk/day\_\_\_\_ 1+pk/day\_\_\_\_ former smoker (year stopped)\_\_\_\_\_\_\_\_

Alcohol Use: None\_\_\_\_ social\_\_\_\_\_ 1/day\_\_\_\_\_2-3/day\_\_\_\_ 4+/day\_\_\_\_ year stopped\_\_\_\_\_

Street Drugs: Never\_\_\_\_\_\_ In the past\_\_\_\_\_\_\_ Occasionally \_\_\_\_\_\_ Frequently\_\_\_\_\_\_\_

**Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_