

Patient Medical Information

Patient Name _____ Date: _____

In order that we may know a little more about you, please answer the following questions about your present problem and medical history.

1.) Briefly describe why you're here:

2.) What made you consider your visit with us today?

3.) Do you have any allergies to medications? Yes No If yes, please list:

4.) Please list all medications you are taking, including vitamins, laxatives, pain relievers, and herbal remedies.

5.) Medical Conditions (check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney/Liver Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart problems/Stroke | <input type="checkbox"/> Pregnant or Breastfeeding | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Severe Allergies | <input type="checkbox"/> Autoimmune Conditions | <input type="checkbox"/> Accutane use within 6 months |
| <input type="checkbox"/> Asthma/Breathing problems | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Skin pigmentation problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> History of Skin Cancer | <input type="checkbox"/> HIV+ or AIDS |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Myasthenia Gravis, ALS, MS, | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> or other Neuromuscular Disease | |

6.) Have you had any past surgeries? If so, please list.

7.) Do you currently smoke cigarettes or use tobacco? Yes No

If yes, how frequently (circle one): Daily Weekly Monthly On occasion

8.) Do you drink alcohol? Yes No

If yes, how frequently (circle one): Daily Weekly Monthly On occasion

9.) What is your preferred pharmacy name?

Patient Medical History

Patient Name _____ Date: _____

Have you ever had any problems or diseases in the areas listed below (check all that apply)? If yes, please explain.

No Yes If yes, Explain.

Head			
Eyes			
Ears			
Mouth			
Throat			
Lungs			
Heart			
Stomach			
Bowels			
Kidneys			
Bladder			
Liver			
Extremities			
Circulation			
Other Areas			

Please list any other medical conditions or problems you may have that were not addressed above.

____/____/____

Patient or Patient Guardian Signature

Date