Date_____ **MEDICAL HISTORY**

Name	DOB	Age	Height	Weight

Pharmacy Name:_____ **Pharmacy Phone Number:**_____

Current Medications

Medication	Dosage	Frequency

Medical History

General	□Alcoholism □History of drug abuse □Type 1 Diabetes □Type 2 Diabetes □Cancer □History of Polio □Thyroid Disease □Pain Management
HEENT	□Hearing problem □Blindness □Glaucoma □Other:_____
Respiratory	□Asthma □COPD □Lung Disease □ Tuberculosis □History of Pneumonia □Other:_____
Auto Immune Deficiency	□Multiple Sclerosis (MS) □Guillain-Barre (GB) □Psoriasis □Inflammatory Bowel Disease (IBD) □Lupus
Blood	□Blood Clotting Disorder □History of Blood Clots □Anemia □HIV □AIDS
Cardiovascular	□Heart Disease □CAD (Coronary Artery Disease) □CHF (Congestive Heart Failure) □High Blood Pressure □History of Heart Attack □History of Stroke □Pacemaker □Defibrillator
Gastrointestinal/ Genitourinary	□Heartburn □History of Ulcers □History of GI Bleed □Bowel Incontinence □Bladder Incontinence □Bowel Disorder □Enlarged Prostate □Pelvic Infection □Liver Disease □Kidney Disease □Kidney Stones □Hepatitis □Post Menopause □pregnant (How many weeks:_____)
Musculoskeletal	□Osteoarthritis □Rheumatoid Arthritis □Gout □Osteoporosis
Neurologic	□Seizure Disorder □Parkinson's □Multiple Sclerosis (MS) □History of Paralysis □Alzheimer's (circle: with/without behavioral disturbance) □Other:_____
Psychiatric	□Anxiety □Depression □Bipolar Disorder □Schizophrenia □ Other: _____
Infections	□MRSA □MSSA □VRE □C-Diff If yes to any, please list dates:_____

Allergies	Reaction/Symptoms

Surgical History			
Location:	**Name of Surgery:**	**Date (mm/dd/yyyy):**	**Surgeon's Name:**
Neck/ Back			
Other			

Family Medical History

If any relatives have ever had any of the following, please check the box and indicated your relationship:

□Adopted □History unknown

□ Seizure disorder	
□ Diabetes	
□ Cancer	
□ Heart Disease	
□ High Blood Pressure	
□ Kidney Disease	
□ Mental Illness	
□ Alcoholism	
□ Stroke	
□ Bleeding Disorders	
□ Spine Problems	

Social History	
Alcohol Use	□No □YES → Type of Alcohol: □Beer □Wine □Liquor → Drinks per week:_____
Smoking	□No → □Former Smoker → Quit Date:_____ □Yes Type of tobacco: □cigarettes □pipe □cigars □hookah pipe □electronic cigarettes □chewing □snus Frequency: □occasionally □once a month □once a week □daily Packs per day: □0.25 □0.5 □1 □1.5 □2

Occupation: □Retired □Student □Disabled □Employed:_____	**Marital Status:** □Single □Married □Divorced □Widowed	**# of Children**
Do you exercise routinely? □Yes □No	**Lives with:** □Alone □Spouse □Partner □Children □Parent(s) □Assisted living	

Review of Systems	
General Information	□chills □fever □weight gain □weight loss
Skin	□bruises easily □rash □bleed easily □wounds
Head, Ears, Eyes, Nose, Throat	□blurred vision □double vision □hearing loss □hoarseness □trouble swallowing □vision loss
Respiratory	□cough □shortness of breath □wheezing
Cardiovascular	□chest pain □irregular heart beat □palpitations □poor circulation
Gastrointestinal	□abdominal pain □bowel changes □constipation □diarrhea □incontinence
Genitourinary	□blood in urine □difficulty with urination □frequent urination □ frequent(recurrent) UTIs
Musculoskeletal	□weakness □back pain □joint pain □joint swelling □muscle pain □neck pain □reduced range of motion □stiffness □swelling
Neurology	□balance difficulty □burning pain □difficulty walking □dizziness □fainting □headaches □impaired memory □peripheral neuropathy □seizures □shakiness □tingling/numbness
Psychology	□loss of sleep □nervousness □stress

Have you had a flu shot?

☐Yes. When? Date _____

☐No. Reason_____

Have you had a pneumonia shot?'

☐Yes. When? Date _____

☐No.

Have you had any falls in the last year?

☐Yes. When? Date _____

☐No.