SELF HISTORY SHEET

Name: _____ **DOB:** _____

Signature:_____ **Date:**_____

Signature indicates that all information given on this sheet is true to the best of my knowledge.

Preferred Pharmacy_____ **Location**:_____

Referring Physician: _____ **Primary Physician:**_____

Reason for your visit:

_____

_____

Past Medical History: Place a Y or N if you have ever had any of the following illnesses:

Arthritis:	_____	High Blood Pressure:	_____	Thyroid Disease:	_____
Asthma:	_____	Heart Disease/A-Fib:	_____	Varicose Veins:	_____
Diabetes:	_____	Renal Failure:	_____	Emphysema/COPD:	_____
Cancer:	_____	Peptic Ulcer:	_____	Stroke:	_____
Specify Type of Cancer:_____				High Cholesterol:	_____

Other Illness not listed above:_____

Past Surgical History: Check here if none [ ]

Date	Procedure	Hospital	Doctor

Medications: (Please list any medications you take, check here if none [ ])

**If you have a separate list, please attach we can return your copy when you come in.

Check here if you are giving us a separate list [ ]

Name of Medication	Dose	How Often do you take it?

Allergies: Check here if you have no known allergies to drugs: ☐

Allergy to Meds: _____

_____

Latex: _____ If yes, what reaction?_____

Seafood: _____ If yes, what reaction?_____

Contrast Dye: _____ If yes, what reaction?_____

Family History: (Circle if any of your immediate family members have had the following illnesses)

Aneurysm:	Dad__Mom__Sis__Bro__	Heart Disease:	Dad__Mom__Sis__Bro__
Anemia/bleeding:	Dad__Mom__Sis__Bro__	High Blood Pressure:	Dad__Mom__Sis__Bro__
Stroke:	Dad__Mom__Sis__Bro__	Kidney Disease:	Dad__Mom__Sis__Bro__
Carotid Disease:	Dad__Mom__Sis__Bro__	Diverticular/Crohn's:	Dad__Mom__Sis__Bro__
Cancer:	Dad__Mom__Sis__Bro__	Diabetes:	Dad__Mom__Sis__Bro__
Specify type of cancer: _____		Malignant Hyperthermia:	Dad__Mom__Sis__Bro__

Other Health issues that family members have had that we should know about:_____

_____

Social History:

Smoking status: Current smoker ____ Former smoker _____ Never _____

Do you use any other tobacco products?_____ If yes, what kind & how often?_____

Do you drink alcohol? _____ If yes, how many drinks per day?_____

Please circle one: Retired / Disabled / Self- Employed / Homemaker / Employed

What type of work do you do? _____

Marital Status: Single_____ Married_____ Divorced _____ Widowed _____

Review of Systems: (Answer all questions with Yes if you CURRENTLY have these symptoms)

Integumentary (skin)

Rashes: _____ Boils/infection: _____ Hair loss: _____

Eye, Ear, Nose, & Throat

Change in Vison: _____ If yes, describe:_____

Change in Hearing: _____ If yes, describe:_____

Difficulty swallowing: _____ Hoarseness : _____

Cardiovascular

Chest Pain/angina:_____ Irregular Heart beat?_____ Leg Ulcers:_____

Leg swelling:_____ Pain In legs after walking?_____ Leg discoloration: _____

Respiratory

Shortness of breath: _____ Wheezing:_____ Chronic chough:_____

Gasto-Intestinal

Pain in abdomen_____ Describe:_____

Changes in appetite:_____ If yes, describe:_____

Weight gain _____ Weight loss_____ Heartburn _____

Vomitting:_____ Blood in vomit?_____ Nausea _____

Diarrhea:_____ Constipation:_____ Bleeding with bowel movements:_____

Pain with bowel movements:_____ Black bowel movements:_____

Genito-Urinary

Blood in urine: _____ Burning or pain when urinating:_____

History of kidney stones: _____ Chronic urinary infection: _____

Women

Number of children:_____ Any miscarriages:_____ Date of last period:_____

Contraceptive use:_____ If yes, state what kind:_____

If you do not menstruate, when did you stop?_____

Musculo-Skeletal

Back pain:_____ Joint pain:_____ Stiffness:_____ Leg pain/cramping:_____

Nervous System

Headache:_____ Fainting:_____ Seizures:_____ Dizziness:_____

Memory loss:_____ Numbness:_____ Weakness:_____ Paralysis:_____

Difficulty sleeping:_____

Heme-Lymph

Easy bleeding: _____ Easy bruising: _____ Discoloration of skin: _____

Lymph node enlargement: _____