

**HEALTH HISTORY**  
**(PLEASE PRINT)**

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

**General Information:**

Patient Name: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Chief complaint or problem (Reason for Visit): \_\_\_\_\_

Date problem began: \_\_\_\_\_

Have you had this problem before? Yes No

**Medications you are currently taking:**

Prescription Name	Prescribed by:
1.	
2.	
3.	
4.	

**Allergies: (eg. Drug, Food)**


Have you or are currently taking drugs not prescribed to you: Yes No  
 If yes, describe: \_\_\_\_\_

Immunizations Current: Yes No  
 (MMR, Hepatitis, Tetanus)

**Prior Major Illnesses and Injuries**


**Surgical History**

Type of Surgery/Procedure	Date/Year

Tobacco Use: Yes No Occasional Socially

Alcohol Use: Yes No Occasional Socially

Illegal Drugs: Yes No Occasional Socially

**Female History:**

Last Menstrual Period: \_\_\_\_\_

Last Pap Smear Test: \_\_\_\_\_

Last Mammogram: \_\_\_\_\_

Self Breast Exam: Yes No

Sexually Active: Yes No

Method of Contraception: \_\_\_\_\_

Total Number of Pregnancies: \_\_\_\_\_: # of Live Births \_\_\_\_\_ # of Abortions (Induced) \_\_\_\_\_ # of Miscarriages \_\_\_\_\_

Have you had the following conditions within the last year? (Please Select)

Conditions	Yes	No
Night Sweats		
Hot Flashes/Hot Flushes		
Pain with Intercourse		
Vaginal Dryness		
Decrease sexual desire		
Decrease Energy		
Fluid Retention		
Bladder Infection		
Urinary Leakage		

Conditions	Yes	No
Mood Swings		
Sleeping Problems		
Difficulty Concentrating		
Memory Loss		
Anxiety		
Depression		
Frequent Headaches		
Migraines		
Sexually Transmitter Disease/STD: (HPV/Warts, Gonorrhea, Syphilis, Herpes)		

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**Family History:**

Mother:

Age \_\_\_\_\_ Living \_\_\_\_\_ Deceased \_\_\_\_\_  
 (Cause of Death \_\_\_\_\_)

Number of Siblings: \_\_\_\_\_  
 Ages: \_\_\_\_\_ #Living \_\_\_\_\_ #Deceased \_\_\_\_\_  
 (Cause of Death \_\_\_\_\_)

Father:

Age \_\_\_\_\_ Living \_\_\_\_\_ Deceased \_\_\_\_\_  
 (Cause of Death \_\_\_\_\_)

Please indicate whether you or your immediate relatives (parents, siblings, grandparents, aunts/uncles, cousins, or children) current have or have had in the past the following illnesses:

Illness	Yes	No
Breast Cancer		
Ovarian Cancer		
Cervical Cancer		
Uterine Cancer		
Colon Cancer		
Heart Attack		
Stroke		
Diabetes		

Illness	Yes	No
Hypertension/High Blood Pressure		
Obesity		
Hyperlipidemia		
Pulmonary embolism		
Deep venous thromboembolism		
Osteoporosis		
Alzheimer's Disease		
Mental Illness		

**Miscellaneous Questions:**

Do you consider your health to be:      Excellent    Good    Fair    Poor

Do you exercise?      Yes    No      what type of exercise \_\_\_\_\_.

Consumption of Caffeine-containing beverages (coffee, tea, cola): \_\_\_\_\_ # of cups per day

Have you lost or gained weight recently?      Yes    No      Usual Weight \_\_\_\_\_

**Additional Information:** (Please use this area to describe any history not discussed above) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Additional Concerns:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



I \_\_\_\_\_ certify that the above information is correct to the best of my knowledge. I will not hold Dr. M. Mitchell Silver or members of his staff responsible for any errors or omissions that I have made in the completion of this form.

\_\_\_\_\_  
 Patient Name/Legal Guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Reviewed By

\_\_\_\_\_  
 Date