

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