Today's Date: ____ / ____ / ______

Patient Name: ____

Preferred Pharmacy Name: ____

Preferred Pharmacy Phone #: ____

Past Medical History (PMHx)			
	Yes		Yes
Abdominal Pain (Recurrent		Eczema	
Acne		GERD(spitting), digestive issues	
ADHD		Headache/Migraine (Recurrent)	
Allergy Symptoms		Heart Disease	
Anemia		High Blood Pressure	
Anxiety		High Cholesterol	
Asthma		Kidney Problems	
Bed Wetting (incontinence)		Learning Problems	
Behavior Disorder/ Problems		Pneumonia	
Bronchitis, chronic		Rash	
Cancer (Type?)		Seizures	
Chronic Ear Infection		Sleep Apnea/ issues	
Constipation		Thyroid Problems	
Depression (Recurrent)		Tuberculosis Exposure	
Developmental Delay		Urinary Tract Infection	
Diabetes (Type?)		Weight loss/gain issues	

Newborn problems (jaundice or difficulties during delivery yes no

Past Surgical History (PSHx)	
Surgery	Date

Medications (Meds)			
Drug	Dosage	Frequency	Reason

Allergies
Medications: No ____ Yes ____ (please describe):
Food: No ____ Yes ____ (please describe):
Allergic to Latex? No ____ Yes ____

Family Medical History (FMHx)

	Mother	Father	Brother	Sister	Grandmother (Paternal)	Grandfather (Paternal)	Grandmother (Maternal)	Grandfather (Maternal)	Aunt	Uncle
Anemia										
Arthritis										
Cancer (Type?)										
Cystic Fibrosis										
Diabetes (Type?)										
Heart Disease										
High Blood Pressure										
High Cholesterol										
Kidney Problems										
Lung Problems										
Mental Problems										

Family Medical History (FMHx)										
Seizures										
Thyroid Problems										
Tuberculosis										
Learning Issues (Type)										
Behavior Issues (Type)										
Digestive Issues (EX. Constipation or Reflux)										

Social History (SHx) over 13 yrs or household	
Alcohol Use	Never ____ Current ____ Former ____
Tobacco Use	Never ____ Current ____ Former ____
Drug Use	Do you use recreational drugs? Yes ____ No ____ Any Guns kept in household Yes ___ No ___ Locked _____