Medical Health History

Name: _____ **Date of Birth/Age:** _____ **Date:** _____

Occupation: _____ **Pharmacy:** _____

Referred by: _____ **Primary Doctor:** _____

Past Medical Problems: _____

_____

_____

Prior Surgeries: _____

_____

_____

Current Medications: _____

_____

_____

Allergies to Medications: _____

Social History: Smoking/Chew: Never _____ **Current** _____ **Past** _____ **Secondhand** _____

How much? _____ **If quit, when?** _____

Alcohol (including beer): Never _____ **Current** _____ **Past** _____

How much? _____ **How often?** _____

Family Medical Problems:
Mark the box of each family member who has a history of the following medical problems:

Relationship	Mother	Father	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Complications from Anesthesia								
Asthma								
Autoimmune Disease								
Bleeding/Clotting Problems								
Cancer								
Diabetes								
High Blood Pressure								
Hearing Problems								
Heart Attack								
Kidney Problems								
Liver Problems								
Lung Problems								
Seizures								
Stomach or Colon Problems								
Stroke								
Thyroid Problems								