Patient Name_____

Chief Complaint_____

PAST HISTORY	**YES**	**NO**
Disease of Heart, Arteries, Veins or Chest Pain	_____	_____
High Blood Pressure	_____	_____
Cancer, Tumor or Polyp, Where _____	_____	_____
Diabetes, , Albumin or Blood in Urine	_____	_____
Asthma, bronchitis, Tuberculosis, Lung Disease	_____	_____
Ulcers, Colitis, DisordeRs of the Stomach, LiveR, Gallbladder	_____	_____
Nervous Breakdown, Mental nervous Disorders	_____	_____
Epilepsy, Unconsiousness, Dizziness	_____	_____
Kidney Stones, Kidney, Bladder Urinary Disease	_____	_____
Arthritis, Rheumatic Fever, Gout, Paralysis Disease	_____	_____
Deformity of Bones	_____	_____
Disease of the Thyroid, Lymph Glands, Anemia, Leukemia or other Blood Disorders	_____	_____
Drugs: Cocaine, barbiturates, or other controlled Substances	_____	_____

HAVE YOU EVER SMOKED?_____DRINK CAFFENIATED BEVERAGES?_____

IF YES, then _____(#) of packs per day. For how many years? _____

Are you still smoking? _____

ALLERGIES TO MEDICATIONS OR OTHER? _____

Alcohol: Yes_____ No_____ How much daily?_____

Patient Name _____

Date of Birth_____

Pharmacy Name_____
Pharmacy Address_____
Phone Number_____

Medication:	**Dosage**:	**Frequency**:	**Purpose**:	**Prescribing Doctor**:

NOTES: