Health History Sheet

Name (Please Print):_____ Email:_____

Primary Care Doctor (PCP):_____ Pharmacy name:_____

Pharmacy address:_____ Registration number:_____

Presenting problem or reason for visit:_____

Check if applicable:

_____ Anemia / Bleeding Problems
_____ Arthritis / Osteoporosis
_____ Cancer
_____ Diabetes
_____ Breathing / Lung Problems
_____ Epilepsy / Seizures
_____ Fainting Spells
_____ Glaucoma / Cataracts
_____ Hepatitis
_____ Heart Attack
_____ Irregular Heart Rate
_____ Kidney Disease
_____ Rheumatic Fever / Murmur
_____ Stroke
_____ Thyroid Disease
_____ Tuberculosis
_____ Ulcers
_____ HIV / AIDS
_____ Heart Disease / Hypertension

Have you ever had a blood transfusion? (*Circle one*) **YES** **NO**

Do You Drink Any Alcoholic Beverages? (*Circle one*) **YES** **NO**

Do You Smoke? (*Circle one*) **YES** **NO** If yes, how long? _____ How Often? _____

Have You Ever Taken Accutane (an acne medication)? (*Circle one*) **YES** **NO**

Have You Ever Taken Viagra? (*Circle one*) **YES** **NO**

What Medications Are You Presently Taking? _____
_____

What Over The Counter Medications/Herbal Supplements/Multi Vitamins/ASA or Aspirin Related Products Are You Taking? _____

Do You Have Any Allergies To Medications? _____

List Any Previous Surgeries: _____

Last Pregnancy: _____ Last Mammogram: _____

SIGNATURE: _____ **Date:** _____