

## PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained herein will not be released to anyone without your authorization to do so.

**Today's Date** \_\_\_\_\_ **Date of Last Physical Exam** \_\_\_\_\_

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **Middle** \_\_\_\_\_

**Social Security No.** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Phone No.** \_\_\_\_\_

**Pharmacy Name** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Referring Physician** \_\_\_\_\_

**Chief Complaint**

*What is the main reason for your visit today? (Describe your problem in detail)*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Physician Use Only (Comments/Notes)**

# Answers	Level of Service
1 - 3	1 or 2
4+	3 - 5

### Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any personal past illnesses and/or Surgeries and when they occurred.

Illness or Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

**Are you on any medications?**    **Y**    **N**    (If yes, list all.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Are you on a special diet?**    **Y**    **N**    (If yes, please explain)

**Do you have allergies?**    **Y**    **N**    (If yes, please explain)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Do you smoke?**                    **Y**                    **N**

If yes, how much? \_\_\_\_\_

**Do you drink alcohol?**        **Y**                    **N**

If yes, how much? \_\_\_\_\_

**Do you drink coffee?**         **Y**                    **N**

If yes, how much? \_\_\_\_\_

**Do you drink tea?**                **Y**                    **N**

If yes, how much? \_\_\_\_\_

**Do you eat chocolate?**    **Y**                    **N**

If yes, how much? \_\_\_\_\_

**Do you drink soft drinks?**   **Y**                    **N**

If yes, how much? \_\_\_\_\_

**Physician Use Only (Comments/Notes)**

# Answers	Level of Service
0	1 or 2
1 - 2	3
3	4 or 5