PURPOSE OF VISIT/HISTORY

Patient Name:_____DOB:_____/_____/_____

Preferred Pharmacy **and location**:_____

Purpose of Visit: _____

Symptoms you are having:_____

How long has the problem(s) been going on ? _____ Is the problem Mild Moderate or Severe

Have you taken medication for this problem? Yes No If so, what medication? _____

Has it helped? Yes No Last Menstrual Period _____/_____/_____ Last Mammogram ____/____/____

Type of Contraception _____

List all current medications and dosage: _____

_____

_____

Allergies: _____

Medical History: past or current illness/disease _____

_____

_____

Family history: Does anyone directly related to you have Cancer, Diabetes, Heart Disease or High Blood Pressure? If so, list if it is Mother, Father, Sibling, or Grandparent; and what condition they have. _____

_____

Do you smoke? Yes or No If yes, how many packs per day /how many years have you smoked.

_____

Surgical History: List all surgeries and approximate year it was done. _____

_____

_____

WHEN COMPLETED PLEASE RETURN TO RECEPTIONIST. THANK YOU