

Your Name: _____ Date: _____

PHARMACY NAME: _____ PHONE #: _____

MEDICATIONS

Pill Name:	Pill Dose (mg)	How Often?	Pill Name:	Pill Dose (mg)	How Often?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

DRUG ALLERGIES

Name of Drug	Type of Reaction
_____	_____
_____	_____
_____	_____

SURGERIES OR HOSPITALIZATIONS?

FAMILY HISTORY

Has anyone in your family ever had:	Yes	No	Relationship
Alzheimer's Disease (dementia)			
Stroke			
Dystonia/Tics			
Mental Illness (depression, substance abuse, etc)			
Parkinson Disease			
Brain Aneurysm (brain bleeding)			
Brain tumor			
Epilepsy			
Migraine			
Other: _____			

REVIEW OF SYSTEMS

WHAT IS YOUR CURRENT HEIGHT ___FT ___IN, AND WEIGHT ____LBS

MARK ANY SYMPTOMS YOU CURRENTLY HAVE:

Constitutional:

- ___ Weight Loss over 5#
- ___ Weight Gain over 5#
- ___ Fevers
- ___ Daytime Sleepiness
- ___ Snoring
- ___ Insomnia

Skin:

- ___ Rash

ENT:

- ___ Headaches
- ___ Vertigo
- ___ Double Vision
- ___ Visual Loss

Cardiovascular:

- ___ Chest Pain
- ___ Fainting
- ___ Palpitations

Respiratory:

- ___ Cough
- ___ Shortness of Breath

Gastrointestinal:

- ___ Appetite Change
- ___ Bloody or Dark Stools

Genitourinary:

- ___ Urinary Incontinence
- ___ Loss of Sexual Interest

Musculoskeletal:

- ___ Muscle Pain
- ___ Weakness

Neuro/Psych:

- ___ Memory Trouble
- ___ Anxiety/Depression
- ___ Numbness
- ___ Slurred Speech
- ___ Difficulty Swallowing

Heme/Endocrine:

- ___ Swollen Lymph Nodes
- ___ Swollen Glands

Other (explain):

For Women: Are you pregnant? Y N Do you use birth control? Y N Are you nursing? Y N
 (Inform the office if you become pregnant!)