# Health History Form

**Patient Name**: _____
**Primary Care doctor**: _____ **Referring physician**: _____
**Preferred pharmacy (local not mail)**: _____
**Pharmacy Location:** **City:** _____ **State:** _____

**Medications** (Please list or provide the clinical staff a copy of prescriptions at appointment)

1._____ 2._____ 3._____
4._____ 5._____ 6. _____
7._____ 8._____ 9._____
10._____ 11._____ 12._____
13._____ 14._____ 15. _____

**Medication Allergies:** **(please include reactions)**

1._____ 2._____ 3._____
4._____ 5._____ 6. _____
7._____ 8._____ 9._____
10._____

**Allergies to Latex? Yes / No** **Allergies to Adhesives? Yes / No**

**Medical History (Please circle all that apply):**

Cancer active/previous: _____ Treated with: Chemo and/or Radiation

| | | |
|---|---|---|
| Ear infections: Y/N | Asthma: Y/N | Other not otherwise specified: |
| Allergies: Y/N | GERD: Y/N | 1. _____ |
| Depression: Y/N | Bleeding disorders: Y/N | 2. _____ |
| Sleep Apnea (CPAP): Y/N | Thyroid Nodules: Y/N | 3. _____ |
| Heart Attack: Y/N; if so, when: __/__ | Hyperthyroidism: Y/N | 4. _____ |
| High blood pressure: Y/N | Hypothyroidism: Y/N | 5. _____ |
| Elevated Cholesterol: Y/N | Anxiety: Y/N | 6. _____ |
| Diabetes Type I or Type II | Stroke: Y/N; if so, when: __/__ | |

**Surgeries:**

_____
_____
_____

**Flu Shot**: Yes/No **Pneumonia shot:** Yes/No
**COVID-19 Vaccine**: Yes/No
**Manufacturer:** Pfizer / Moderna / Johnson and Johnson

**Family History**: **(***Please include Cancer, Bleeding Disorders, Hearing loss or Thyroid Disorders)*

**Mother:** _____ **Father:** _____

**Siblings:** _____ **Grandparents:** _____

**Social History (Please circle all that apply):**
**Current: ❑ Smoking ❑ Smokeless tobacco ❑ Cigars ❑ Vaping**
**Past: ❑ Smoking ❑ Smokeless tobacco ❑ Cigars ❑ Vaping**
**Alcohol use: Y/N Type: Beer/Wine/Liquor**