Name:		Date of Birth: Married / Single / Other
Height:	Weight:	Reason for visit:
Pharmacy:		Pharmacy Phone Number:

Medical Problems	Past Surgeries
History of HIV/AIDS? Yes / No	

Medication	Dose	Medication	Dose

Allergies and Reactions:	Family History (Cancer, Diabetes, ETC.)	
1.	1.	○Mother ○Father ○ Sibling
2.	2.	○Mother ○Father ○ Sibling
3.	3.	○Mother ○Father ○ Sibling
4.	4.	○Mother ○Father ○ Sibling
5.	5.	○Mother ○Father ○ Sibling
6.	6.	○Mother ○Father ○ Sibling

Social History		Occupation:
Is your job: ○ Heavy ○Moderate ○ Light		**History of Drug abuse or Drug addiction:** Yes or No
Do you smoke: Yes or No	**Alcohol Use:** Never / Occasionally / Daily	**History of heavy alcohol use:** Yes or No

General		Cardiovascular		Neurological	
Fatigue	Yes / No	Swelling of Extremities	Yes / No	Tingling	Yes / No
Skin		Edema	Yes / No	**Psychological**	
Excessive Sweating	Yes / No	Hypertension	Yes / No	Change in Sleep Patterns	Yes / No
Itching	Yes / No	**Gastrointestinal**		Anxiety	Yes / No
HEENT		Nausea	Yes / No	**Endocrine**	
Hearing Loss	Yes / No	Constipation	Yes / No	Cold Intolerance	Yes / No
Blurred Vision	Yes / No	Diarrhea	Yes / No	Hot Intolerance	Yes / No
Respiratory		**Musculoskeletal**		**Hematology**	
Cough	Yes / No	Joint Pain	Yes / No	Easy Bruising	Yes / No
		Muscle Cramps	Yes / No		

To the best of my knowledge, the above information is accurate.

Patient/Guardian Signature:_____