

PAST SURGICAL HISTORY

Please place a check mark in the box if you have ever had any of the following surgeries. Also, if you know the year, please include it.

	Year		Year		Year
<input type="checkbox"/> Angioplasty		<input type="checkbox"/> Gastric Bypass		<input type="checkbox"/> Tubal Ligation	
<input type="checkbox"/> Angioplasty with Stent		<input type="checkbox"/> Hernia Repair		<input type="checkbox"/> Cesarean Section	
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Hip Replacement		<input type="checkbox"/> D and C	
<input type="checkbox"/> Arthroscopic Knee Surgery		<input type="checkbox"/> Knee Replacement		<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Back Surgery		<input type="checkbox"/> Lasik		<input type="checkbox"/> Mastectomy	
<input type="checkbox"/> Brain Surgery		<input type="checkbox"/> Liver Biopsy		<input type="checkbox"/> Myomectomy	
<input type="checkbox"/> CABG/Bypass Surgery		<input type="checkbox"/> Neck Surgery		<input type="checkbox"/> Breast Biopsy	
<input type="checkbox"/> Carpal Tunnel		<input type="checkbox"/> Pacemaker		<input type="checkbox"/> Breast Augmentation	
<input type="checkbox"/> Cataract		<input type="checkbox"/> Sinus Surgery		<input type="checkbox"/> Breast Reduction	
<input type="checkbox"/> Cholecystectomy (Gallbladder)		<input type="checkbox"/> Thyroidectomy		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Colectomy (Colon Removed)		<input type="checkbox"/> Tonsillectomy		<input type="checkbox"/> Other: _____	

WEIGHT	HEIGHT	HAVE YOU TAKEN CORTIZON-TYPE DRUGS?
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SOCIAL HISTORY & HEALTH MAINTENANCE

Do you use tobacco now? <input type="checkbox"/> Yes <input type="checkbox"/> No Quit Date: _____	In the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type & Daily Amount	How Long	Ever used Smokeless Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use alcohol now? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type	Weekly amount	How Long?	Ever use/used illegal drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____

Marital Status (Please Circle): Married Single Divorced Widowed

Review of Systems (circle those that apply):

Constitutional:

Weight loss
Fever
Excessive sweating

Eyes:

Double vision
Blurred vision
Cataracts

Ears:

Hearing loss
Ringing in ears
Vertigo

Respiratory:

Cough
Shortness of breath
Asthma

Cardiovascular:

Chest pain
Irregular heartbeat
Fainting

Gastrointestinal:

Abdominal pain
Nausea
Vomiting

Genitourinary:

Pain with urination
Difficulty urinating
Incontinence

Endocrine:

Hot/cold intolerance
Increased urination
Skin changes

Musculoskeletal:

Joint pain
Muscle pain
Back pain
Neck pain
Limb pain

Neurological:

Tremor
Weakness
Numbness
Unsteady gait
Memory loss

Psychiatric:

Anxiety
Mood Swings
Depression

PHARMACY INFORMATION

Preferred Pharmacy Name Pharmacy Phone Number Pharmacy Address