Patient Medical History

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Allergies

☐ No Known Allergies

Medicine | Other

Current Medications (include non-prescription products)

☐ No Current Medications

1. _____ 3. _____ 5. _____ 7. _____

2. _____ 4. _____ 6. _____ 8. _____

Preferred Pharmacy

Pharmacy Name: _____ Location: _____

Do you use the Doctors Care In-Center Pharmacy? ☐ Yes ☐ No - *Explain Aidarex*

Patient History

PLEASE MAKE AN (X) BY ANY OF THESE CONDITIONS YOU MAY HAVE HAD IN THE PAST:

☐ Heart disease	☐ Kidney, bladder or prostate disease	☐ Stroke	☐ Mental health problems
☐ High blood pressure	☐ Joint replacement	☐ Seizures	☐ Depression
☐ High cholesterol	☐ Liver disease	☐ Nerve impairment	☐ Chronic skin disease
☐ Lung disease	☐ Bowel disease	☐ Cervical spine disorder	☐ Sleep apnea
☐ Diabetes	☐ Cancer (past or present)	☐ Lumbar spine disorder	☐ Other:
☐ Hypoglycemia (low glucose)	☐ Anemia or other blood disease	☐ Severe headaches	_____
☐ Thyroid disease	☐ Blood clots	☐ Tuberculosis/TB	_____
☐ Stomach disease	☐ Bleeding tendency	☐ Muscle disease	_____

PAST MEDICAL CONDITIONS:

Approximate Date Condition | Approximate Date Condition

Approximate Date Condition | Approximate Date Condition

ORTHOPEDIC OR OTHER MAJOR SURGERIES:

Approximate Date Surgery | Approximate Date Surgery

Approximate Date Surgery | Approximate Date Surgery

Family History

Mother:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Father:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Brother:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Sister:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandmother (M):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandmother (P):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandfather (M):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandfather (P):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A

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Personal Habits

Do you drink alcoholic beverages? ..... ☐ Yes ☐ No If yes, _____ drinks per ☐ Day ☐ Week ☐ Month

Do you smoke or chew tobacco?..... ☐ Yes ☐ No If yes, _____ per day, _____ years of use

Do you use an e-cigarette?..... ☐ Yes ☐ No If yes, _____ per day, _____ years of use

Review of Symptoms

	Do you have		If yes, explain
SKIN	Rashes, bumps, lumps, open sores, or wounds	☐ Yes ☐ No	
HEAD | EYES | EARS NOSE | THROAT	Failing eyesight, falls, seizures, vertigo, blackouts, hoarseness, or nasal congestion	☐ Yes ☐ No	
LUNGS	Unexpected breathlessness, wheezing (day or night), blood in sputum, or chronic cough	☐ Yes ☐ No	
HEART	Chest pain, irregular heartbeat, or pacemaker	☐ Yes ☐ No	
BOWELS	Blood in stool, change in bowel habits, worrisome indigestion, or abdominal pain	☐ Yes ☐ No	
BLADDER | KIDNEY	Trouble urinating, infections, or blood in urine	☐ Yes ☐ No	
EMOTIONAL	Any mental health problems, depression, or suicidal tendency	☐ Yes ☐ No	
MUSCULOSKELETAL	Arthritis, fractures, injuries, muscle weakness, or cramping	☐ Yes ☐ No	

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