PATIENT HEALTH HISTORY QUESTIONNAIRE

atient Name: _____DOB: _____ Date: _____

Vhat pharmacy do you use? _____ City: _____

Vho is your Primary Care Doctor? _____

HISTORY OF PRESENT ILLNESS:

- Where is the problem located: _____
- How long have you had this problem:_____
- How did you hurt yourself: _____
- What symptoms is the patient having:_____
- Does anything make the problem better or worse:_____
- Is patient taking any medication to treat this problem:_____
- Does the problem interfere with normal daily activities? (circle one) **YES** **NO**

)n a scale of 1 – 10 (10 is the worst) circle the number that describes your pain **1 2 3 4 5 6 7 8 9 10**

PAST MEDICAL HISTORY:

las the patient EVER had any of the following? (circle if yes)

nemia	Pacemaker	Bipolar	Hepatitis	Seizure Disorder
troke	Asthma or COPD	Anxiety	Kidney Disease	Kidney Stones
leart Attack	Diabetes	Depression	Liver Disease	Glaucoma
leart Disease	GERD	Arthritis	Thyroid Disease	Tuberculosis
ligh Blood Pressure	Allergies	HIV	Stomach Ulcer	High Cholesterol

)ther Illnesses:_____

PAST SURGICAL HISTORY:

ist all the operations or surgery the patient has **ever** had, along with the date of surgery.

. _____ 2. _____ 3. _____

. _____ 5. _____ 6. _____

. _____ 8. _____ 9. _____

FAMILY HISTORY:

; patient's mother still living?____ If no, please list age and cause of death _____

)id/Does your mother have any of the following? (***If yes, please circle***)

)IABETES HYPERTENSION CANCER HEART DISEASE PSYCHIATRIC DISORDER ARTHRITIS

; patient's father still living?_____ If no, please list age and cause of death _____

)id/Does your father have any of the following? (***If yes, please circle***)

)IABETES HYPERTENSION CANCER HEART DISEASE PSYCHIATRIC DISORDER ARTHRITIS

of Sisters? _____ # of Brothers? _____ # of Sons _____ # of Daughters? _____

MEDICATION LIST

NAME: _____ ***DATE*** _____

PHARMACY: _____

DATE OF BIRTH: _____ ***SS#:*** _____

MEDICATION ALLERGIES/SENSITIVITIES

_____

_____

MEDICATION NAME	***STRENGTH***	***DOSAGE***