



## PERSONAL MEDICAL HISTORY

Please indicate if you have ever experienced any of the following conditions listed.

Anxiety	Yes	No		Arthritis	Yes	No
Asthma	Yes	No		Cancer	Yes	No
Bleeding disorder	Yes	No		Depression	Yes	No
Diabetes	Yes	No		Epilepsy (seizures)	Yes	No
Glaucoma	Yes	No		Hay fever (allergies)	Yes	No
Heart attack (myocardial infarction)	Yes	No		Heart failure	Yes	No
High blood pressure (hypertension)	Yes	No		High cholesterol (Hyperlipidemia)	Yes	No
Insomnia	Yes	No		Kidney disease	Yes	No
Lung disorder (COPD/emphysema)	Yes	No		Migraine headaches	Yes	No
Osteoporosis	Yes	No		Stroke	Yes	No
Thyroid disorders	Yes	No		Ulcers or heartburn /GERD	Yes	No
Attention deficit disorder/ADHD	Yes	No		Chronic pain	Yes	No
Other:				Other:		

<b>Do you currently exercise?</b>	Never	Regularly	Times per week:	Average number of minutes per workout:
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**Immunization History:** Screened by pharmacy

### Review of Systems

Please circle if you are CURRENTLY experiencing any of the following.

<b>General</b>	Weight gain/loss	Headache	<b>Head, Ear, Eye</b>	Changes in vision	Changes in hearing
	Fatigue	Dizziness		Sore mouth	Bloody nose
<b>Cardiovascular</b>	Chest pain	Palpitations	<b>Respiratory</b>	Shortness of breath	Cough
	Dizzy when rising	Bleeding		Wheezing	Sputum
				Chest Tightness	
<b>Digestive</b>	Heartburn	Nausea/vomiting	<b>Mood</b>	Changes in sleep pattern	Suicidal thoughts
	Abdominal pain	Diarrhea		Difficulty focusing	Anxiety
	Constipation				
<b>Extremities</b>	Excessive bruising	Numbness/tingling	<b>Muscles/Bones</b>	Back pain	Joint pain
	Rash	Foot sores		Muscle weakness	Muscle pain
				Muscle cramps	
<b>Neuro</b>	Memory loss	Fainting	<b>Genitourinary</b>	Blood in urine	Impotence
	Migraine headaches			Incontinence	Burning

### To be Completed at the Pharmacy

<b>Immunizations needed per screening:</b>		<b>Blood Pressure</b>	
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