

Patient Medical History Form

Name: _____	Date of Birth: ___/___/___	Age: ____	Sex: ____
Pharmacy Name: _____		Pharmacy Address: _____	

Primary Care Physician and Therapist	
Primary Care Provider: _____	Therapist: _____

Past Medical History			
Condition / Disease	Year	Condition / Disease	Year
<input type="checkbox"/> Anxiety		<input type="checkbox"/> Narcolepsy	
<input type="checkbox"/> Depression		<input type="checkbox"/> Insomnia	
<input type="checkbox"/> Bipolar		<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Schizophrenic		<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Gender Dysphoria		<input type="checkbox"/> Cancer	
<input type="checkbox"/> ADHD		<input type="checkbox"/> Drug Abuse	
<input type="checkbox"/> OCD		<input type="checkbox"/> Alcohol Abuse	
<input type="checkbox"/> PTSD		<input type="checkbox"/> Other:	
<input type="checkbox"/> Anorexia / Bulimia / Binge Eating		<input type="checkbox"/> Other:	

Psychiatric Hospitalizations / Past Surgical Procedures / Serious Injuries or Fractures			
Operation / Hospitalization / Injury	Month / Yr	Operation / Hospitalization / Injury	Month / Yr
1:		4:	
2:		5:	
3:		6:	

Allergies or Intolerance(s)			
List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)			
Allergen	Reaction	Allergen	Reaction
1:		4:	
2:		5:	
3:		6:	

Current Medication(s)			
Medication	Dosage	Medication	Dosage
1:		6:	
2:		7:	
3:		8:	
4:		9:	
5:		10:	

Social, Educational and Work History

Marital Status (Circle One): Single Married Widowed Divorced Separated

Work Status (Circle One): Employed Unemployed Student Retired Disabled

Employer or School: _____

Do you drink alcohol? Yes No Number of drinks per week? _____

Are you a smoker? Yes No If yes, how many packs per day? _____

Are you a former smoker? Yes No If yes, what year did you quit? _____

Do you smoke e-cigarettes/Vape? Yes No If yes, how often? _____
What type of substance do you Vape? _____

Do you smoke marijuana? Yes No If yes, how often? _____

Family Medical History

I am unsure of my family history

I am adopted

Condition / Disease	Mother	Father	Sister	Brother	Other (Please Specify)
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Please Specify Alive/Deceased, if deceased please specify when and how	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□ _____
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Please Specify Date of Birth and/or age of Family Member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□ _____
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□ Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□ _____
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□ Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□ _____
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□ Bipolar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□ _____
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□ Schizophrenic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□ _____
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□ ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□ _____
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□ OCD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□ _____
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□ PTSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□ _____
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□ Anorexia / Bulimia / Binge Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□ _____
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□ Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□ _____
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□ Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□ _____
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□ Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□ _____
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□ Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□ _____
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□ Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□ _____
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Additional Note(s)
