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PATIENT'S NAME \_\_\_\_\_ MI \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

**PHARMACY INFORMATION**

Pharmacy Name: \_\_\_\_\_

Location: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**HEALTH HISTORY**

List any childhood illnesses you have had: \_\_\_\_\_

\_\_\_\_\_

List all medical conditions you are being treated for: \_\_\_\_\_

\_\_\_\_\_

List any injuries (fractures, sprains, dislocations, wounds): \_\_\_\_\_

\_\_\_\_\_

List and date all previous surgeries: \_\_\_\_\_

\_\_\_\_\_

List and date all previous hospitalizations: \_\_\_\_\_

\_\_\_\_\_

List all current medications and the dosages you take: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List allergies: \_\_\_\_\_

\_\_\_\_\_

Do you have any chronic illnesses? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list: \_\_\_\_\_

\_\_\_\_\_

(continued)

**FAMILY MEDICAL HISTORY**

List any family history of illnesses: \_\_\_\_\_

\_\_\_\_\_

**SOCIAL/PERSONAL HISTORY**

Occupation: \_\_\_\_\_

Are you currently working?: Yes\_\_\_\_ No\_\_\_\_

Do you smoke? Yes\_\_\_\_ No\_\_\_\_

If yes, amount per day: \_\_\_\_\_

Did you previously smoke? Yes\_\_\_\_ No\_\_\_\_

If yes, amount per day: \_\_\_\_\_

Do you drink alcohol? Yes\_\_\_\_ No\_\_\_\_

If yes, amount per day: \_\_\_\_\_

\_\_\_\_\_