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Personal History Form

Last Name: ______________________________ **First Name:** _______________ **Date:** ____________________

Home Phone: ___________________________ **Pharmacy:** ____________________________ **Sex:** ( ) **Male** ( ) **Female**

Work Phone: ___________________________ **Pharmacy Phone:** ____________________ **Date of Birth:** ___-___-___

Allergies to Medications:
☐ None
1. ________________________________
Reaction: __________________________
____

Current Medications
☐ None
1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________
6. ________________________________

Aspirin/Motrin/Advil	☐ Yes	☐ No
Coumadin	☐ Yes	☐ No
Birth Control Pills	☐ Yes	☐ No
Are you breast feeding	☐ Yes	☐ No
Are you pregnant	☐ Yes	☐ No
Plan on becoming pregnant	☐ Yes	☐ No

Review of Systems Screen *(Current or past problems with)*

	Yes	No		Yes	No		Yes	No
Blood/Bleeding Disorders	☐	☐	Arthritis	☐	☐	Cancer	☐	☐
Heart Disease	☐	☐	Diabetes (sugar)	☐	☐	Immunologic Disease	☐	☐
Kidney Disease	☐	☐	High Blood Pressure	☐	☐	Latex/Rubber/Nickel/Food	☐	☐
Liver Disease or Hepatitis	☐	☐	Infectious Disease (TB, HIV)	☐	☐	Skin Disease	☐	☐
Lung Disease	☐	☐	Received Blood Transfusions	☐	☐	Skin Cancer	☐	☐
Thyroid Disease	☐	☐	Psychological Disorders	☐	☐	Melanoma	☐	☐

Do you:

	Yes	No		Yes	No
Have a pacemaker or defibrillator	☐	☐	Have an artificial joint or heart valve	☐	☐
Take antibiotics prior to surgical procedures	☐	☐	Form Keloids	☐	☐

List surgeries:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

Family History (*Check the following medical conditions which have occurred in your family)*

Disease	Mother	Father	Blood Relative	None	Disease	Mother	Father	Blood Relative	None
Acne	☐	☐	☐	☐	Hay Fever	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	Hives	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	Lupus	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Melanoma	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Psoriasis	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	Skin Cancer	☐	☐	☐	☐

Social History

	Yes	No		Yes	No		Yes	No
Do you live alone?	☐	☐	Do you drink alcohol?	☐	☐	Do you use recreational drugs?	☐	☐

Frequency ______________________ (alcohol)
Frequency ______________________ (recreational drugs)

Occupation ________________________________ Hobbies/Leisure activity ________________________________

Patient Signature: ____________________________________ Date: ____________________________