Patient Pharmacy Information

Patient Name: _____ Acct #: _____

Date of Birth: _____ SS #: _____

Insurance: _____ ID #: _____

Pharmacy Name: _____

Address/Location: _____

Pharmacy #: _____ Alt #: _____

Drug Allergies:

_____

_____

_____

For Office Use Only

Vital Signs: Temp_____ B/P_____ Resp. _____ O2 Sat _____ % HR _____ Weight_____ Date _____ Height _____

PERSONAL INFORMATION

Name: _____ Date of Birth____/____/____ Age: ___

Home Ph: (___)_____-_____ Work Ph: (___)____-_____ Cell Ph: (___)_____ - _____

Emergency Contact: _____ Relationship:_____ Phone: (___)___ - _____

PHYSICIAN INFORMATION

Referring Physician: _____ City/State: _____ Phone: (___) ____ - _____

Medical Oncologist: _____ City/State: _____ Phone: (___) ____ - _____

Surgeon: _____ City/State: _____ Phone: (___) ____ - _____

Primary Care Physician: _____ City/State: _____ Phone: (___) ____ - _____

Other: _____ City/State: _____ Phone: (___) ____ - _____

HISTORY OF PRESENT ILLNESS

What were your initial symptoms? _____

When did they begin? _____

Who did you initially see to address the problem? _____

Which of the following test have been done to investigate the problem?

TEST	DATE	TEST	DATE
CT SCAN		PET SCAN	
MRI		BONE SCAN	
MAMMOGRAM		COLONOSCOPY	
BIOPSY		BRONCHOSCOPY	
SURGERY		OTHER (please list)	

Have you ever had chemotherapy? ☐ Yes ☐ No

If so, list the type of chemotherapy give: _____

What were the dates of treatment? _____

Have you ever had radiation therapy? ☐ Yes ☐ No

If so, what area was treated? _____

What were the dates of treatment? _____

CURRENT MEDICATIONS: Please bring list of medications, if you need additional space

Medications	Dose	Frequency	Prescribed By

HERBS/SUPPLEMENTS

ALLERGIES

☐ None ☐ Contrast Dye ☐ Surgical Tape ☐ Seasonal Allergies ☐ Shellfish

☐ Other: (please list) _____

Medication Allergy	Type of Reaction

_____

MD Initials

MEDICAL HISTORY **(please check any of these you have been diagnosed with and indicate the year diagnosed)**

√		*Year*		√		*Year*
	Cataracts				History of Colon Polyps	
	Glaucoma				Kidney Failure	
	Difficulty Hearing				Kidney Stones	
	Thyroid Disease or Goiter				Cystitis or Bladder Infections	
	Chronic Bronchitis/Emphysema/COPD				Urinary Tract Infections	
	Asthma				Arthritis	
	Tuberculosis				Multiple Sclerosis	
	Irregular Heart Beat				Parkinson's disease	
	Heart Murmur				Other Neurologic Problems	
	High Blood Pressure				Lupus	
	High Cholesterol				Scleroderma	
	Congestive Heart Failure				Skin Condition	
	Heart Attack				Other Collagen Disease	
	Angina				Blood Clots or Clotting Disorder	
	Stroke or paralysis				Anemia	
	Pacemaker/Defibulator				Seizures or Epilepsy	
	Hernia				Depression	
	Ulcerative Colitis				Severe Anxiety	
	Ulcers of Stomach or Duodenum				Psychiatric Treatment	
	Crohns Disease				Diabetes or Sugar	
	Irritable Bowel Syndrome				History of falls	
	Diverticular disease				HIV/AIDS	
	Hepatitis or Liver Disease				Other:	
	Pancreatitis				Other:	

PAST SURGICAL HISTORY

Type of Surgery	Date of Surgery	Surgeon	Hospital	Complications

FAMILY HISTORY

Relation to You		Diseases	Cause of Death
Mother	☐Alive ☐ Deceased		
Father	☐Alive ☐ Deceased		
Sister	☐Alive ☐ Deceased		
Brother	☐Alive ☐ Deceased		
Maternal Grandmother	☐Alive ☐ Deceased		
Paternal Grandmother	☐Alive ☐ Deceased		
Maternal Grandfather	☐Alive ☐ Deceased		
Paternal Grandfather	☐Alive ☐ Deceased		
Aunt/Uncle	☐Alive ☐ Deceased		
Other:	☐Alive ☐ Deceased		

Other medical problems that run in the family:

MD Initials

GYNECOLOGIC HISTORY (female only)

Age at first menstrual cycle: _____ Last menstrual period: _____ Age at menopause: _____
Age at first pregnancy: _____ # of pregnancies: _____ # of live births: _____
Did you breast feed? ☐ Yes ☐ No Did you/do you use birth control? ☐ Yes ☐ No
Duration of birth control pill use: _____ Duration of hormone replacement therapy: _____
Bra Size: _____ Age at first mammogram: _____Date of last mammogram_____
GYN Problems/Infections: _____
Date of last PAP Smear? _____ Where was it performed? _____
Are you sexually active? ☐ Yes ☐ No If yes, age when you became sexually active: _____

PROSTATE HISTORY (male only)

Age at first PSA: _____ Is your PSA checked regularly? ☐ Yes ☐ No
Are you sexually active? ☐ Yes ☐ No
If yes, do have impotence or difficulty with erection? ☐ Yes ☐ No
Have you had a TURP (Roto-rooter)? ☐ Yes ☐ No
If yes, what was the date of the surgery? _____
How many times do you urinate during the night? _____
Have you had prostate infections? ☐ Yes ☐ No
If yes, what are the dates of the infection? _____

SOCIAL HISTORY

Personal Situation: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated
Children's ages: Boys_____ Girls _____

Living Situation: ☐Home ☐Apartment ☐Mobile Home ☐Nursing Home ☐Assisted Living
Name/address: _____

How many people live with you?_____ Any pets? ☐ Yes ☐ No, Type: _____

Highest Education: ☐High School ☐Trade School ☐College ☐Graduate School

Current Work Situation: ☐Full-time ☐ Part-time ☐Medical leave ☐Retired
Occupation: _____

Tobacco use: ☐None ☐Cigarettes ☐Cigars ☐Snuff/Chew ☐Pipe
How old were you when you started smoking? _____ How many years have you smoked?_____
Are you still smoking? ☐ Yes ☐No If no, when did you quit? _____
If yes, how many packs per day do you smoke? _____ Are you interested in quitting ☐Yes ☐ No

Alcohol Use: ☐None ☐Beer ☐Wine ☐Liquor
How old were your when you started drinking? _____ Do you have a history of alcohol abuse ☐Yes ☐No
Are you still using alcohol? ☐Yes ☐No If no, when did you quit? _____
If yes, how many drinks do you have per week? _____ Are you interested in quitting? ☐Yes ☐No

Drug Use: ☐None ☐Marijuana ☐Cocaine ☐Heroin ☐Amphetamines
How old were you when you started using drugs? _____Do you have a history of drug abuse? ☐Yes☐No
Are you still using drugs? ☐Yes ☐No If no, when did you quit?_____
If yes, how often do you use drugs? _____ Are you interested in quitting? ☐Yes ☐No

Exercise/Activities: _____Frequency of exercise/activities: _____

Please describe any emotional/spiritual/cultural practices that may influence your medical care:

_____

Would you like to discuss advanced care planning? ☐Yes ☐No

Do you have a living will? ☐Yes ☐No

_____
MD Initials

REVIEW OF SYSTEMS (circle all that apply)

EYES		**GASTROINTESTINAL**		**NEUROLOGIC**	
Corrective lenses	Vision loss	Nausea	Constipation	Headaches	Tingling
Cataracts	Black spots	Vomiting	Abdominal pain	Weakness	Tremors
Blurred vision	Other	Black Stool	Bloody stool	Numbness	Imbalance/falls
Double vision		Hemorrhoids	Gas	Dizziness	Difficulty walking
Tunnel vision		Jaundice	Other	Seizures	Other
		Diarrhea		Decreased coordination	
EARS/NOSE		**URINARY**		**LYMPHATIC/HEMATOLOGIC**	
Hearing loss	Decreased smell	Pain	Night-time urination	Swollen glands	
Earache	Sinus trouble	Burning	Weak stream	Decreased blood counts	
Vertigo	Nose bleeds	Frequency	Blood in urine	Easy bruising	
Ear pain/ringing	Other	Incontinence	Other	Other	
CARDIOVASCULAR		**MUSCULOSKELETAL**		**SKIN/HAIR**	
Chest pain/pressure	Murmur	Back/neck pain	Stiffness	Hair Loss	Rash
Leg/arm swelling	Irregular heart beat	Bone pain	Other	Itching	Other
Palpitations	Other	Joint pain		Ulcers	
Difficulty lying flat		Decreased range of motion		Change in skin color	
LUNG		**THROAT**		**MOUTH**	
Dry cough	Other	Hoarseness		Mouth pain	
Productive cough		Change in voice		Dental problems	
Coughing up blood		Difficulty swallowing		TMJ	
Shortness of breath		Painful swallowing		Oral ulcers	
Pain with inspiration		Other		Other	
BREAST		**GYNECOLOGIC**		**GENERAL**	
Swelling	Lumpy breast	Vaginal discharge	Pelvic pain	Fever	Weight gain
Pain	Breast mass	Bleeding	Other	Chills	Weight loss
Nipple discharge	Other	Itching		Fatigue	Night sweats
Skin changes		Painful intercourse		Loss of appetite	Other
PSYCHIATRIC		**OTHER ISSUES/COMPLAINTS:**			
Depression	Irritability				
Anxiety	Other				
Claustrophobia					
Trouble Sleeping					

_____
MD Initials

Fall Risk Assessment Tool for Age 65+	
Core Elements Assess one point for each core element	**Points**
Diagnosis (3 or more co-existing)	
Prior history of falls within 3 months	
Urinary Incontinence (urgency, frequency, and/or nocturia)	
Visual Impairment (includes any eye disease)	
Impaired Functional Mobility (arthritis, impaired sensation, unsteady gait, etc.)	
Environmental Hazards (poor lighting, inappropriate foot wear, clutter, etc.)	
Poly Pharmacy (4 or more prescriptions- any type)	
Pain affecting the level of function	
Cognitive Impairment	
TOTAL: A score of 4 or more is considered at risk for falling	

Depression Screening Tool

Over the last two weeks, how often have you been bothered by any of the following problems?
(Circle the number to indicate your answer)

Questions	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
Add Columns		+	+	
TOTAL				
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not at all difficult _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____			

***If there are at least 4 numbers circled in the shaded section, consider depression. May add columns for severity

Vaccine History

Type of Vaccine	Date
Influenza	
Pneumococcal	

Pain Assessment

Are you experiencing pain?	☐ Yes ☐ No
Location of pain?	
How does the pain feel? Sharp, dull, burning, etc.	
Severity? Circle one	1 2 3 4 5 6 7 8 9 10
How long ago did it start?	
When does it bother you?	
What happens to cause the pain?	
What makes it better?	
What makes it worse?	
Any other signs and symptoms associated with pain?	

Patient Signature _____ Date _____ Nurse Signature _____ Date _____ MD Initials _____

Patient Name: _____ **Date:** _____

Pharmacy Name/Location: _____

Patient Medication List

Please list all medications you are presently taking, including all prescriptions, vitamins, herbs, supplements, and over the counter medications.

Name of Medication	Dose