NAME ______________________ DATE_______________

Pharmacy name and phone number____

1. Chief Complaint: Symptoms? Are you BETTER WORSE or UNCHANGED? Hx PI Reviewed

2. Since Your Last Visit: What Tests have been done? Results? Been Hospitalized? Yes No Why?

3. LIST ANY CHANGES TO YOUR CURRENT MEDICATIONS (or provide medication list)

Current Medications	**Dosage**	**Frequency (how often)**
1.		
2.		
3.		
4.		
5.		
6.		

4. Have you had NOW or RECENTLY any of the following: yes no Please check

NEURO	memory difficulty numbness or paralysis one side headache loss of coordination tingling dizziness _________
GENERAL	Weight gain or loss of___ lbs fever fatigue sleep problem _________
EYE	decreased vision R L double vision eye pain _________
ENT	swallowing problems hearing loss ringing in ears TMJ problem _________
RESP	shortness of breath cough congestion wheezing _________
CV	chest pain palpitation edema fainting _________
GI	nausea diarrhea cramps abdominal pain _________
GU	bladder infections loss of bladder control/wetting yourself trouble voiding prostate
GYN	new pregnancy menstrual problems started hormones breast problem _________
MUS-SKEL	joint pains neck pain back pain muscle cramps _________
SKIN	rash itching hair loss hair growth _________
PSYCH	hallucinations anxiety attacks panic attacks depressed confusion _________
ENDO	diabetes hypoglycemia low thyroid _________
HEME	bleeding bruising or swollen glands _________
ALLERGY	hayfever asthma frequent or unusual infections HIV or AIDS test _________

5. Any change in your smoking or drinking habits, marital status, job, family history Yes No