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Today's Date: _____

Patient Name: _____
Gender: M ☐ F ☐ DOB: _____

Pharmacy: _____ Pharmacy Location: _____

Primary Care Physician: _____

Why are you here today? _____

DO YOU HAVE ANY KNOW ALLERGIES: **YES** ☐ **NO** ☐

IF YES, WHAT ARE YOU ALLERGIC TO? _____

LIST ALL MEDICATIONS YOU TAKE, INCLUDING OVER THE COUNTER AND SUPPLEMENTS:

LIST ALL SURGICAL PROCEDURES YOU'VE HAD, INCLUDING ALL MAJOR AND MINOR PROCEDURES, INCLUDING UROLOGY

LIST ALL CURRENT AND PAST MEDICAL PROBLEMS YOU HAVE BEEN DIAGNOSED WITH:

LIST ALL MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY AND WHO WAS AFFECTED:

MARITAL STATUS: MARRIED ☐ DIVORCED ☐ SINGLE ☐ SEPERATED ☐ WIDOWED ☐
TOBACCO USE: NEVER SMOKED ☐
CURRENT_____ PACK PER DAY SMOKER FOR ____ YEARS
DO YOU DRINK ALCOHOL: NO ☐ YES ☐ DRINKS PER WEEK _____
ILLICIT DRUG USE: NO ☐ YES ☐ _____
DO YOU DRINK CAFFEINATED BEVERAGES? ☐NO ☐YES _____ DRINKS PER DAY