PATIENT MEDICAL HISTORY

Name: ____________________ Date of Birth: ____________

Date: ____________ Account #: ____________

Patient Ethnicity: ____________ Patient Race: ____________ Patient Language: ____________ Declined: ____________

Pharmacy of Choice and location: ____________

Are you diabetic?: _____ yes _____no

ALLERGY

Are you **ALLERGIC** to any **MEDICATIONS**? ____No ____Yes If yes, please list below

Other Allergies: ______No ______Yes ( ) **Metal** **( ) Iodine** **( ) Shellfish** **( ) Latex**

Other: ____________

MEDICATION HISTORY

Please List **ALL** Medications you are presently taking? (as well as over the counter, herbs, supplements)

Medication	Dosage	Frequency	Prescribing Doctor

Signed by: ____________

Patient/Guardian Signature