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	Date Started	Prescribing Doctor

Signed by: _____

Patient/Guardian Signature