# Patient History Form

UF | UNIVERSITY of FLORIDA

Patient Name: _____ Date: _____

Pharmacy Preference: _____ MRN: _____

Referring Physician: _____ Primary Care Physician: _____

Reason for Visit: _____

**CURRENT MEDICATIONS: PRESCRIPTION/NON-PRESCRIPTION**

| NAME OF MEDICATION | STRENGTH/ DOSE | HOW DO YOU TAKE IT? |
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**ALLERGIES: Include Medication, Food, Seasonal, etc.**

| NAME OF MEDICATION | DESCRIBE ADVERSE REACTION |
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**MEDICAL HISTORY:**

| | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Allergies | | | COPD | | | Meningitis | | | Iritis | | |
| Anemia | | | Depression | | | Nerve / muscle disease | | | Glasses/contact lenses | | |
| Anxiety | | | Diabetes mellitus | | | Osteoporosis | | | Crossed eyes | | |
| Arthritis | | | Emphysema | | | Seizures | | | Lazy eye | | |
| Asthma | | | GE Reflux | | | Sickle Cell | | | Keratoconus | | |
| Blood Transfusion | | | Glaucoma | | | Stroke | | | Macular degeneration | | |
| Cancer | | | Heart Attack | | | Substance Abuse | | | Retinal detachment | | |
| Cataracts | | | Heart Murmur | | | Thyroid Disease | | | Others: | | |
| CHF | | | HIV/AIDS | | | Tuberculosis | | | | | |
| Clotting disorder | | | Kidney Disease | | | Ulcers | | | | | |
| Hypertension | | | Hyperlipidemia | | | Anesthetic Complications | | | | | |

**SURGICAL HISTORY:**

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Appendectomy | | | C-Section | | | Prostate surgery | | |
| Brain surgery | | | Eye surgery | | | Small intestine surgery | | |
| Breast surgery | | | Fracture surgery | | | Spine surgery | | |
| CABG | | | Hernia repair | | | Tubal ligation | | |
| Cholecystectomy | | | Hysterectomy | | | Valve replacement | | |
| Colon Surgery | | | Joint replacement | | | Vasectomy | | |
| Cosmetic surgery | | | Refractive surgery | | | Retina surgery | | |
| Cataract surgery | | | Glaucoma surgery | | | Cornea surgery | | |

**SOCIAL HISTORY:**

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| **Smoker: Current: Packs/day: _____ Former: Quit Date: _____ Years Smoked: _____** |
| **Smokeless Tobacco: Current / Former / Never Used.** |
| **Alcohol: Yes / No Drinks / week: Wine glasses: ____ Beer cans: ____ Liquor shots: ____ Other: _____** |
| **Drug Use: Yes / No Marijuana: Yes / No Cocaine: Yes / No IV Drugs: Yes / No Other: _____** |

**FAMILY HISTORY:**

| | Amblyopia | Cataract | Genetic Eye Disorders | Glaucoma | Macular Degeneration | Retinal Detachment | Vision Loss | Arthritis | Asthma | Autoimmune Disorders | Cancer | Diabetes | Heart Disease | Hypertension | Stroke |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mother | | | | | | | | | | | | | | | |
| Father | | | | | | | | | | | | | | | |
| Sister | | | | | | | | | | | | | | | |
| Brother | | | | | | | | | | | | | | | |
| M Aunt | | | | | | | | | | | | | | | |
| M Uncle | | | | | | | | | | | | | | | |
| P Aunt | | | | | | | | | | | | | | | |
| P Uncle | | | | | | | | | | | | | | | |
| MGM | | | | | | | | | | | | | | | |
| MGF | | | | | | | | | | | | | | | |
| PGM | | | | | | | | | | | | | | | |
| PGF | | | | | | | | | | | | | | | |

**CURRENT MEDICAL COMPLAINTS: Do you have any of the following currently:**

**Heart problems: chest pain / irregular heart beat / other** _____

**Respiratory problems: coughing / shortness of breath / wheezing / other** _____

**General problems: chronic fever / fatigue / unexpected weight gain / unexpected weight loss / other** _____

**ENT problems: hearing loss / sinus problems / sore throat / other** _____

**Gastrointestinal problems: abdominal pain / diarrhea / heartburn and vomiting / other** _____

**Urinary problems: blood in urine / pain / discomfort / other** _____

**Skin problems: excessive dryness / rash / other** _____

**Musculoskeletal problems: joint pain / muscle aches / swollen joints / other** _____

**Neurologic problems: headaches / numbness / paralysis and weakness / other** _____

**Psychiatric problems: anxiety / depression / other** _____

**Endocrine problems: cold intolerance / excessive thirst / heat intolerance / other** _____

**Hematologic problems: easy bleeding / lymph node enlargement / other** _____

**Allergic / Immunologic problems: hay fever / frequent infections / other** _____