PATIENT NAME: _____

PHARMACY:_____ **CITY:**_____ **LOCATION:**_____

Have you had in the past or are presently having a problem with:

Condition	Yes
Anxiety	
Arthritis	
Asthma	
Atrial Fibrillation (Irregular heartbeat)	
Bone Marrow Transplantation	
Breast Cancer	
Colon Cancer	
COPD/Pulmonary Disease	
Coronary Artery Disease	
Depression	
Diabetes	
End Stage Renal Disease	
Enlarged Prostate	
GERD/Reflux	
Hearing Loss	
Hepatitis	
High Blood Pressure	
HIV/AIDS	
High Cholesterol	

Condition	Yes
Hyperthroidism	
Hypothroidism	
Leukemia	
Lung Cancer	
Lymphoma	
Prostate Cancer	
Radiation Treatment	
Seizures	
Stroke	
Anemia/Bleeding Disorder	
Blood Clots in lungs	
Chronic Headaches	
Gallbladder Disease	
Heart Attack	
Inflamed Pancreas	
Kidney Problems	
Pacemaker	
Phlebitis	
Sickle Cell Disease	

Any other medical problems not listed above? _____

Check if you have a previous history of: ❑ Basal Cell ❑ Squamous Cell ❑ Melanoma
Other _____

Check if you have a family history of: ❑ Basal Cell ❑ Squamous Cell ❑ Melanoma
Other _____

Do you have allergies to any drugs, food, ointments, creams, make-up, jewelry? ❑ Yes ❑ No
If yes, please list _____

Have you had surgery in the last three years? ❑ Yes ❑ No
If yes, why? _____

Are you currently taking an aspirin daily? ❑ Yes ❑ No

Are you currently taking a blood thinner daily? ❑ Yes ❑ No If yes, what medication?: _____

Are you currently taking any other medication daily? ❑ Yes ❑ No If yes, please list:

_____ _____ _____ _____

_____ _____ _____ _____