



**Immunizations:**

- |                                    |                                |                                  |                                   |
|------------------------------------|--------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Influenza | <input type="checkbox"/> MMR   | <input type="checkbox"/> Covid   | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio | <input type="checkbox"/> Tetanus |                                   |
| <input type="checkbox"/> Varicella | <input type="checkbox"/> DPT   | <input type="checkbox"/> HPV     |                                   |

**Family History**

- |  |  |
|--|--|
| <input type="checkbox"/> No known family history of medical conditions | <input type="checkbox"/> Stroke                                    |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Thyroid Disease                           |
| <input type="checkbox"/> Diabetes                                      | <input type="checkbox"/> Kidney Disease                            |
| <input type="checkbox"/> Heart Disease                                 | <input type="checkbox"/> Mental Health (Depression, Anxiety, etc.) |
| <input type="checkbox"/> High Blood Pressure                           | <input type="checkbox"/> Autoimmune Diseases                       |
| <input type="checkbox"/> High Cholesterol                              | <input type="checkbox"/> Other: _____                              |

**Social History**

Factor	Check One	Most Recent Date
Tobacco Use	<input type="checkbox"/> Cigaretts <input type="checkbox"/> Vaping <input type="checkbox"/> Tobacco	
Alcohol Use	<input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy	
Recreational Drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Caffeine	(_____) Times per week	
Exercise Routine	(_____) Times per week	
Sleep	(_____) Hours a night	
Occupation:		Phone # of Employer:

**Check any symptoms that you are experiencing:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Fatigue                      | <input type="checkbox"/> Sleep Disturbances      | <input type="checkbox"/> Chest Pain/Tightness      |
| <input type="checkbox"/> Fever or Chills              | <input type="checkbox"/> Hearing Loss/Ringing    | <input type="checkbox"/> Palpitations              |
| <input type="checkbox"/> Unexplained weight loss/gain | <input type="checkbox"/> Sore Throat/Hoarseness  | <input type="checkbox"/> Swelling in Legs/Feet     |
| <input type="checkbox"/> Shortness of Breath          | <input type="checkbox"/> Abdominal Pain          | <input type="checkbox"/> Blood in Urine            |
| <input type="checkbox"/> Chronic Cough                | <input type="checkbox"/> Nausea/Vomiting         | <input type="checkbox"/> Headaches/Migraines       |
| <input type="checkbox"/> Wheezing                     | <input type="checkbox"/> Diarrhea/Constipation   | <input type="checkbox"/> Dizziness/Lightheadedness |
| <input type="checkbox"/> Joint Pain or Stiffness      | <input type="checkbox"/> Depression/Feeling Down | <input type="checkbox"/> Numbness/Tingling         |
| <input type="checkbox"/> Back Pain                    | <input type="checkbox"/> Anxiety/Panic Attacks   | <input type="checkbox"/> Vision Change             |
| <input type="checkbox"/> Other:                       |  |  |

**Specialist/Other Providers**

## Pharmacy

Patient Name:

Date:

Patient Signature:

Date: