



Name: _____ D.O.B. _____ Age: _____ Date: _____

What problem are you here to have evaluated? _____

Please inform us of which pharmacy you prefer:

Please list any changes in your medications since your last visit:

1) Med: _____ Strength: _____ Times/Day: _____	6) Med: _____ Strength: _____ Times/Day: _____
2) Med: _____ Strength: _____ Times/Day: _____	7) Med: _____ Strength: _____ Times/Day: _____
3) Med: _____ Strength: _____ Times/Day: _____	8) Med: _____ Strength: _____ Times/Day: _____
4) Med: _____ Strength: _____ Times/Day: _____	9) Med: _____ Strength: _____ Times/Day: _____
5) Med: _____ Strength: _____ Times/Day: _____	10) Med: _____ Strength: _____ Times/Day: _____

Please circle or underline any symptoms you presently have:

General: fever, chills, sweats, fatigue, weakness, poor appetite, weight loss, weight gain, other _____

Head: injury, headache, facial pain, hair loss, other _____

Eyes: glasses/contacts, injury, pain, redness, irritation, itching, drainage, change in vision, double vision, foreign body sensation, sensitivity to light, other _____

Ears: injury, pain, discharge, hearing problems, ringing in ears, other _____

Nose: congestion, stuffiness, runny nose, discharge, nosebleed, other _____

Throat: soreness, painful swallowing, toothache, gum swelling or bleeding, sores in mouth or throat, painful tongue, other _____

Neck: injury, pain, lumps, goiter, other _____

Breasts: injury, pain, lumps, discharge, other _____

Heart: chest pain or pressure, irregular heart beat or palpitations, rapid heart beat, trouble breathing, leg swelling, other _____

Lungs: short of breath, cough, sputum (what color? _____), wheezing, painful breathing, other _____

Abdomen: injury, pain, nausea, vomiting, diarrhea, constipation, indigestion, heartburn, gas, black BM's, blood in stool, rectal pain, hemorrhoids, hernia, other _____

Urinary: burning, urgency, frequent urination, back or flank pain, blood in urine, loss of bladder control, decreased urine stream, other _____

Female Genital: Last Menstrual Period _____, sores, discharge, pain, menstrual problems, abnormal vaginal bleeding, painful intercourse, impaired sexual function, other _____

Male Genital: sores, discharge, pain, impaired sexual function, other _____

Muscle/ Skeletal: injury, muscle or joint pains, joint swelling, neck pain, back pain, calf pain, swelling, stiffness, other _____

Skin: laceration, injury, wound, rash, itching, other _____

Neuro: fainting, blackouts, seizures, numbness or loss of sensation, weakness, paralysis, tremors, loss of balance, other _____

Psych: anxiety, depression, stress, sleep problems, hallucinations, suicidal thoughts, domestic violence, other _____

Endocrine: heat or cold intolerance, excessive sweating, excessive thirst or hunger, excessive urination, Other _____

Heme/Lymph: bruising, bleeding, swollen lymph nodes (glands), other _____

Allergic/Imm: HIV/AIDS, infection, allergies, other _____