NAME: **DOB:**

BRIEFLY TELL US WHY YOU ARE HERE:

PHARMACY:

LOCAL: NAME: _____ PHONE _____
CROSSROADS: _____ ZIP: _____

MAIL IN: NAME: _____ PHONE: _____
CROSSROADS: _____ ZIP: _____

PAST OR PRESENT MEDICAL CONDITIONS: ☐ NONE

GASTROINTESTINAL
- ☐ HEPATITIS A
- ☐ HEPATITIS B
- ☐ HEPATITIS C
- ☐ JAUNDICE
- ☐ CIRRHOSIS
- ☐ LIVER DISEASE
- ☐ PEPTIC ULCER DISEASE
- ☐ CROHN'S DISEASE
- ☐ LACTOSE INTOLERANCE
- ☐ ULCERATIVE COLITIS
- ☐ PANCREATITIS
- ☐ GALLSTONES
- ☐ POLYPS
- ☐ COLON CANCER
- ☐ IBS (IRRITABLE BOWEL SYND)
- ☐ DIVERTICULITIS
- ☐ BARRETT'S
- ☐ GERD
- ☐ ESOPHAGEAL DISORDER

ENDOCRINE
- ☐ OSTEOPOROSIS
- ☐ OSTEOPENIA
- ☐ DIABETES
- ☐ THYROID PROBLEMS

CARDIOVASCULAR
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HIGH TRIGLYCERIDES
- ☐ HISTORY OF HEART ATTACK
- ☐ HISTORY OF ANGINA
- ☐ CONGESTIVE HEART FAILURE
- ☐ ATRIAL FIBRILLATION
- ☐ OTHER HEART RHYTHM DISTURB.
- ☐ CARDIAC STENTS
- ☐ ARTIFICIAL VALVES

RESPIRATORY/LUNG
- ☐ CHRONIC BRONCHITIS
- ☐ EMPHYSEMA
- ☐ ASTHMA
- ☐ HISTORY OF LEG CLOTS
- ☐ SLEEP APNEA (WITH STUDY)
- ☐ OXYGEN USE

GENITOURINARY
- ☐ KIDNEY STONE
- ☐ KIDNEY FAILURE
- ☐ KIDNEY DISEASE
- ☐ DIALYSIS
- ☐ PROSTATE CANCER
- ☐ PROSTATE ENLARGEMENT

PSYCHOLOGY
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ PANIC ATTACKS
- ☐ OTHER _____

HEMATOLOGY
- ☐ ANEMIA
- ☐ BLOOD DISORDER
- ☐ HIV

NEUROLOGY
- ☐ MIGRAINE
- ☐ STROKE
- ☐ T.I.A. (MINI STROKE)
- ☐ SEIZURE

RHEUMATOLOGY
- ☐ ARTHRITIS
- ☐ FIBROMYALGIA
- ☐ AUTOIMMUNE DISEASE
- ☐ (LUPUS, R.A.)

EYE
- ☐ GLAUCOMA
- ☐ CATARACTS
- ☐ CONJUNCTIVITIS

ALLERGIES: ☐ NO KNOWN ALLERGIES

LATEX ALLERGY? ☐ - NO ☐ - YES
MEDICATION ALLERGIES: ☐ - NO ☐ - YES, PLEASE LIST

FAMILY MEDICAL HISTORY: ☐ NONE

POSITIVE HISTORY	☐ COLON CANCER	☐ COLON POLYPS	☐ NO KNOWLEDGE OF FAMILY HISTORY	☐ OTHER CANCERS
IF YES, WHAT RELATION:				

IS YOUR MOTHER LIVING	☐ YES	☐ NO, CAUSE OF DEATH:	
IS YOUR FATHER LIVING	☐ YES	☐ NO, CAUSE OF DEATH:	
SIBLINGS? # ___ F / M	☐ YES	☐ NO, CAUSE OF DEATH:	
F / M	☐ YES	☐ NO, CAUSE OF DEATH:	
F / M	☐ YES	☐ NO, CAUSE OF DEATH:	
F / M	☐ YES	☐ NO, CAUSE OF DEATH:	

SOCIAL HISTORY **NAME:** **DOB:**

TOBACCO

DO YOU SMOKE? ☐ - YES ☐ - NO

IF YES, HOW MANY PACKS PER DAY? ____

FOR HOW MANY YEARS? ______________

IF QUIT, WHEN? ________________

ILLICIT DRUG USE ☐ - YES ☐ - NO

DRUG OF CHOICE ___________________

DATE OF LAST USE __________________

ALCOHOL USE

DO YOU DRINK? ☐ - YES ☐ - NO

IF YES, WHAT TYPE?

BEER LIQUOR WINE |

HOW OFTEN? ______________________

HOW MANY GLASSES PER OCCASION? ___

BLOOD TRANSFUSION

☐ - NO ☐ - YES, WHEN?

____

CAFFEINE USE

DO YOU DRINK? ☐ - YES ☐ - NO

IF YES WHAT TYPE?

TEA COFFEE SODA

HOW MANY CUPS PER DAY? CIRCLE ONE

1 2 3 4 5 >5

TATTOOS

☐ - YES # ______ ☐ - NO

DO YOU EXERCISE? ☐ - **NO** ☐ - **YES** → ☐ - **LIGHT** **OR** ☐ - **MODERATE**

TYPE:	HOW OFTEN?

CURRENT MEDICATIONS: ☐ **NONE** **OR** ☐ **SEE ATTACHED LIST (PLEASE INCLUDE NAME, DOSE, FREQUENCY)**

PLEASE ASK RECEPTIONIST FOR ADDITIONAL PAGE IF NEEDED

NAME	DOSE	FREQUENCY

PROCEDURES/SURGICAL HISTORY NAME: DOB:

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

COLONOSCOPY		NO		YES	DATE:	FINDINGS;
ERCP		NO		YES	DATE:	FINDINGS;
UPPER ENDOSCOPY-EGD		NO		YES	DATE:	FINDINGS;
BONE DENSITY ☐ NO ☐ YES DATE:						
OTHER SURGERIES:					DATE:	FINDINGS;

REVIEW OF SYSTEMS:

IN THE PAST 2 – 3 MONTHS, HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?

CONSTITUTIONAL
- ☐ RECENT WEIGHT CHANGES
- ☐ EXCESSIVE FATIGUE
- ☐ FEVER
- ☐ CHILLS

ENMT
- ☐ RECENT CHANGE IN VISION
- ☐ EYE REDNESS
- ☐ RINGING IN EARS/TINNITUS
- ☐ NOSE BLEEDS
- ☐ SINUSITIS
- ☐ SORE THROAT
- ☐ HOARSENESS/VOICE CHANGES
- ☐ RECURRENT MOUTH ULCERS

CARDIOVASCULAR
- ☐ CHEST PAIN/PRESSURE
- ☐ PALPITATIONS
- ☐ SWELLING IN FEET/ANKLES
- ☐ CRAMPS WITH EXERCISE

RESPIRATORY
- ☐ SHORTNESS OF BREATH
- ☐ PERSISTENT COUGH
- ☐ COUGHING BLOOD
- ☐ WHEEZING

GENITOURINARY
- ☐ BLOOD IN URINE
- ☐ BURNING WITH URINATION
- ☐ DIFFICULTY WITH URINATION
- ☐ UP AT NIGHT TO URINATE
- ☐ FREQUENT URINATION

FEMALE
- ☐ PREGNANT NOW
- ☐ MENOPAUSAL SYMPTOMS
- ☐ HEAVY PERIODS
- ☐ IRREGULAR PERIODS

ENDOCRINE
- ☐ INCREASED THIRST

HEMATOLOGIC/LYMPHATIC
- ☐ PAST BLOOD TRANSFUSION
- ☐ SWOLLEN/TENDER LYMPH NODE
- ☐ BRUISE EASILY

MUSCULOSKELETAL
- ☐ JOINT PAIN
- ☐ JOINT STIFFNESS/SWELLING
- ☐ BACK PAIN
- ☐ NECK PAIN
- ☐ DIFFICULTY WALKING

GASTROINTESTINAL
- ☐ DIFFICULTY SWALLOWING
- ☐ PAINFUL SWALLOWING
- ☐ FILL UP QUICKLY AT MEALS
- ☐ NAUSEA OR VOMITING
- ☐ ABDOMINAL PAIN
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ BLOATING
- ☐ GAS
- ☐ INCOMPLETE EVACUATION OF BOWELS
- ☐ BLOOD IN STOOL OR ON TOILET PAPER
- ☐ LOSS OF CONTROL OF BOWEL

NEUROLOGICAL
- ☐ FREQUENT HEADACHES
- ☐ NUMBNESS
- ☐ FOCAL WEAKNESS
- ☐ USE OF CANE/WALKER

PSYCHIATRIC
- ☐ EXCESSIVE SADNESS
- ☐ EXCESSIVE NERVOUSNESS
- ☐ INSOMNIA

INTEGUMENTARY
- ☐ NEW RASH
- ☐ ITCHING