Today's Date___________ Date of Birth:___________Patient Name:_____________________________

Reason for Visit:____

Preferred Pharmacy Name:____________________________________Pharmacy Phone #:____________

Pharmacy Location/Address:____

Past Medical History (PMHx) Please Check All that Apply

____Anxiety
____Arthritis- **Please Circle**
- Osteoarthritis
- Psoriatic
- Rheumatoid

____Cancer - type:______________
____Coronary Artery Disease (CAD)
____Degenerative Disc Disease
____Depression
____Diabetes (High Blood Sugar)
____Heart Disease
____High Cholesterol
____High Blood Pressure
____Irritable Bowel Syndrome
____ Low Thyroid
____ High Thyroid
____Chronic Obstructive Pulmonary Disease (COPD)
____Seizure
____HIV/Aids

Urologic History:

____Abdominal Pain
____Back Pain
____Bladder Displacement
____Blood in Urine
____Burning
____BPH

____Difficult Voiding
____Elevated PSA
____Erectile Dysfunction
____Incontinence
____Kidney Disease
____Kidney Stones
____Waking to Urinate @ night/times ___

____Overactive Bladder
____Prostate Cancer
____Prostatitis
____Renal Failure
____Urinary Frequency
____Urinary Tract Infection (UTI)

____Urinary Retention
____Urinary Urgency
____Vaginal Discharge

List Any Other Below:___________________________
____
____

Past Surgical History (PSHx) Please List Below

Surgery/Date of
Surgery:____
____
____
____
____
____
____
____

Please be sure to list dates of each surgery if there is more than one.

Medication List (Meds) Please List All Below

Drug	Dosage	Frequency	Reason for Medication

Allergies **Please List All Known**

Allergies to Medications: Yes___ No ____ If yes please explain:____

____

Food Allergies: Yes____ No____ If yes please explain:________________

Allergic to Latex? Yes___ No_____

Any other Known Allergies? Please explain

____