Patient Health and Medical History Intake Form

Name: _____ Date: _____ Age: _____

Sex (circle one): M/ F Ht:_____ Wt:_____

Race/Ethnicity: (can select multiples)

- ☐ White
- ☐ Black/African American
- ☐ Hispanic/Latino/Spanish Origin
- ☐ American Indian/Native Alaskan
- ☐ Asian
- ☐ Other (Please describe)_____

Past Medical History

Medical Conditions

- ☐ High blood pressure
- ☐ Diabetes
- ☐ High cholesterol
- ☐ Asthma
- ☐ COPD
- ☐ Ulcers (stomach/intestine)
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Stroke
- ☐ Kidney disease
- ☐ Anxiety
- ☐ GERD (acid reflux)
- ☐ Depression
- ☐ Cancer
- ☐ Depression Cancer
- ☐ Heart attack
- ☐ Irregular heartbeat (atrial fibrillation)
- ☐ Insomnia (difficulty sleeping)
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Other:_____

Hospitalizations

Cause	Date of occurrence

Past Surgical History

- ☐ Appendectomy
- ☐ Angioplasty (balloon surgery) or stent
- ☐ CABG (bypass surgery)
- ☐ Hip replacement
- ☐ Knee replacement
- ☐ Pacemaker / defibrillator
- ☐ Depression Cancer
- ☐ Live births # _____
- ☐ Other: _____

Family History *(mother, father, brother, sister, children)-make sure to indicate which family member suffers from which condition*

- ☐ High blood pressure
- ☐ Diabetes
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Stroke
- ☐ Kidney disease
- ☐ Depression Cancer
- ☐ Other:_____

☐ Living family members: ☐ Deceased family members:

Social History

Exercise _____Minutes _____Times per week

Caffeine _____ cups/day

Alcohol _____ drinks/week Alcohol type(Beer, wine, Distilled Spirits): _____

Tobacco (20 cigs./pack) _____Pack/day _____years

☐ Current ☐ Past ☐ Never

Illicit drugs:

☐ Current ☐ Past ☐ Never

Marital Status

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employment History:
Name of employer: _____ _____ Position: _____
☐ Current ☐ Past ☐ N/A

Medication History (include all medicines: prescribed, over-the-counter, vitamins, herbal medicines; take information from patient medication bottles)

Schedule medications

Name (brand & generic) /Strength	Dose	When taken….	Take for….	Start Date	Beers Criteria drug (place check mark)	Black Box warning drug (place check mark)	Doctor

PRN medications

Name (brand & generic)/Strength	Dose	When taken….	Take for….	Start Date	Frequency of use (x per week)	Beers Criteria drug (place check mark)	Black Box warning drug (place check mark)	Doctor

Medication adherence:

- ☐ Yes. Adherent to medications & techniques being used to maintain adherence
- ☐ No. Not adherent to medications(select reasons below):
  - ☐ Cost prohibitive
  - ☐ Too many medications
  - ☐ Uncertain as to benefit of medication
  - ☐ Forgot to take
  - ☐ Forgot to refill
  - ☐ Other(describe):

Immunizations (when did you last receive the following immunizations?):

- ☐ Influenza_____
- ☐ Tetanus/diphtheria/pertussis_____
- ☐ Hepatitis B_____
- ☐ Hepatitis A_____
- ☐ Herpes zoster (shingles)_____
- ☐ Pneumococcal_____

Allergies (include medication and food):

Medication(and dose)/Food Allergy	Date of occurrence	Description of reaction

Intolerances (include side effects from previous foods/ medications, such as nausea, constipation, sleepiness, dizziness, stomach upset, etc.):

Medication/Food Intolerance	Description of Intolerance

Vitals:

Blood pressure (trend→ try to get a week of readings)

- ☐ Date
- ☐ Arm
- ☐ Medication/not on medications

Heart rate (trend→ try to get a week of readings)

BMI and Ideal Body Weight calculations:

Temperature (°F):

Respiratory rate:

Height:

Labs (include labs that will be needed to monitor medication efficacy/safety. Try to trend labs as much as possible.):
(Add additional rows if needed)

Laboratory Study	**Result**	**Units**	**Date**	**Normal Range (insert here)**
Serum Creatinine				
Estimated Creatinine Clearance (calculated value)				
BUN				
BUN : SCr ratio (calculated)				
Na				
Cl				
K				
CO_2 or Bicarb Content				
Fasting Blood Glucose				
Blood Glucose (random)				
Hemoglobin A1c				
Hematocrit				
Hemoglobin				
Platelet Count				
White Blood Cell Count				
Total Bilirubin				
AST				
ALT				
Total Cholesterol				
HDL				
LDL				
Triglycerides				
TSH				

T3				
T4				
Drug levels (Digoxin, CMZ, etc.)				

Other Studies (EKG, x-rays, biopsies, etc.)

Other Study	Summary of Findings

Reference:

1. **Delivering Medication Therapy Management Services. Patient Health and History Review. [PowerPoint]. Austin, TX: APhA National Certificate Training Program for Pharmacists. 2014.**
2. **Woelfel JA, Boyce E, Patel RA. Instructional Design and Assessment: Geriatric Care as an Introductory Pharmacy Experience. American Journal of Pharmaceutical Education. 2011; 75(6) Article 115.**