VICTORIA SQUARE COMPOUNDING PHARMACY

MEDICAL HISTORY INFORMATION

1) PATIENT INFORMATION: **TODAY'S DATE**

NAME_____BIRTHDATE:_____

ADDRESS: _____CITY:_____

PROV/POSTAL CODE_____PH:_____WK:_____

EMAIL_____PAYMENT: PLEASE NOTE C CARD # BELOW:

_____EXP DATE: _____

GENDER: MALE FEMALE HEIGHT: _____ WEIGHT: _____

2) LIFESTYLE INFORMATION: DO YOU USE? Y OR N IF YES, HOW OFTEN/HOW MUCH

TOBACCO (smoke, chew, dip) _____ _____

ALCOHOL (beer, wine, hard liquor) _____ _____

CAFFEINE (colas, coffee, tea) _____ _____

IMPAIRMENTS: Check if you have any of the following:

Physical Impairment _____ Visual Impairment _____ Hearing Impairment _____

EXERCISE: Do you exercise regularly? ___Y ____N If Yes: Please note exercise & how often:

STRESS MANAGEMENT: Do you practice stress management techniques? ___Y ____N If Yes, pls describe:

DIET: Describe your typical daily food intake:
Breakfast:

Lunch:

Supper:

Any Snacks/other:

3) DOCTOR INFORMATION: Please list each Dr. from whom you seek care with address & phone number.

4) ALLERGIES: please check all that apply: ___None Known

__penicillin __morphine __dye allergies __pet allergies __seasonal

__codeine __aspirin __nitrate allergy __sulfa __food allergies __Other

Note allergic reaction: _____

_____

5) OVER THE COUNTER (OTC) ISSUES: Please check all products used regular or occasionally.

__pain reliever _combination (cold + cough reliever) __aspirin

__sleep Aids (Unisom, Nytol) __acetaminophen __antidiarrheals (eg. Immodium)

__ibuprofen (eg. Motrin) __laxatives (eg. Doxidan) __naproxen (eg. Aleve)

__diet aids (eg.Dexatrim) __ketoprofen __antacids (eg.Maalox)

__cough suppressant (eg.RobitussinDM) __acid blockers (eg.Pepcid AC)

__antihistamine __decongestant (eg.sudafed)

__other: _____

__Nutritional/Natural Supplements: Pls identify and list products you are using:
-herbs, vitamins, minerals, supplements, enzymes, others

6) MEDICAL CONDITIONS/DISEASES. Please check all that apply to you.

__heart disease __lung condition __headaches

__high cholesterol __diabetes __eye disease

__high blood pressure __arthritis or joint problems __thyroid disease

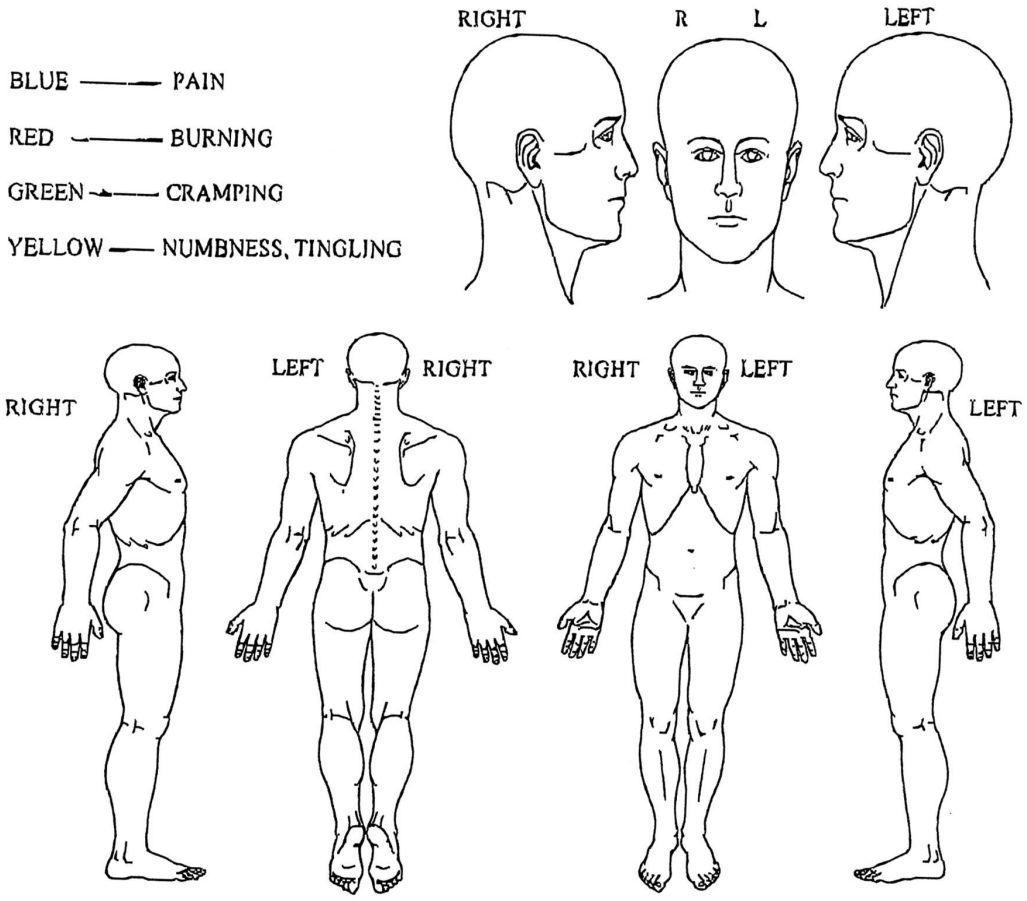
__cancer __depression __hormonal related issues

__ulcers __epilepsy __blood clotting problems

__other: _____

7) PRESCRIPTION MEDICATION: List all prescription medication you are using (include physician samples)

Name	Dose	How many times a day?	Doctor



NAME_____DATE_____

Circle the number that best describes your pain, 0 is NO PAIN and 10 is WORST IMAGINABLE PAIN.

Circle the number that best describes your pain at its worst during the last month.

0 1 2 3 4 5 6 7 8 9 10

Circle the number that best describes your pain at its least during the last month.

0 1 2 3 4 5 6 7 8 9 10

Circle the number that best describes your pain on average during the last month.

0 1 2 3 4 5 6 7 8 9 10

Circle the number that best describes your pain as it is right now.

0 1 2 3 4 5 6 7 8 9 10