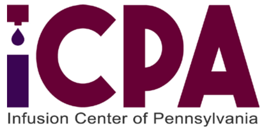

ICPA Medical History Form

This is a fillable PDF. If you received this form electronically, you can complete it on your computer by typing your answers in the spaces provided.

I. PRESCRIPTION INFORMATION

Patient Name:		Age:		Date:	
Drug Prescribed:		Condition for which This Drug was Prescribed:			

II. ALLERGIES

☐ No known allergies

Allergic To	Reaction

III. OTHER MEDICATIONS YOU ARE TAKING

☐ I have attached one or more additional/separate page(s) with this information

Prescription Drug	For	Dose	Frequency	Started	Ended

Current Over-the-Counter Medications (including vitamins, supplements):	

IV. OTHER MEDICAL CONDITIONS

Are you currently being treated, or have you been treated in the past, for any of the following:

☐ Heart Disease	☐ Anemia	☐ Cancer
☐ Hypertension	☐ Diabetes	☐ Kidney/Bladder problems
☐ Stroke	☐ Thyroid problems	☐ Liver problems/Hepatitis
☐ COPD	☐ Neurological problems	☐ Ulcers/Colitis
☐ Asthma	☐ Seizures	☐ Infectious Disease

☐ Any other serious medical conditions you think we should know about:

V. ADULT IMMUNIZATIONS or SCREENINGS

If you have had any of these tests or immunizations, check the box. If you don't know the date, you may leave blank.

	TB Screening			IgE Level	
	Hepatitis B Panel or Vaccine			JVC Screen	
	Eosinophil Count			Meningococcal Vaccine	
	Thyroid FX Test			Allergy Test	
	CBC Screen			Blood Glucose	
	HIV Screen			Pregnancy Test	
	Varicella Titer Test				

VI. RECENT HOSPITALIZATIONS OR SURGERY

If you have had surgery or been hospitalized overnight, please provide details and approximate date(s).

If you need to attach additional pages, please put your name on each.

THIS FORM IS CONFIDENTIAL WHEN COMPLETED
PLEASE BRING WITH YOU TO YOUR APPOINTMENT – DO NOT EMAIL