Patient Information

Name ________________________________ DOB ___/____/_______

Please list preferred pharmacy name and number
Pharmacy Name _____________________________ Pharmacy Number (____) _____- _______

To my valued patients, thank you for taking the time to complete this information sheet, it will help us provide you with a higher quality of care in a more efficient fashion.

Return Patient Information Sheet

What brings you to see us today? ____

Since we last saw you has any of your information changed?

If it has please indicate the new updated information below:

Phone Number Yes ______________________________ No___

Your Address Yes ______________________________ No___

Insurance changes Yes ______________________________ No___

New Medications Yes ______________________________ No___
Please list the medication and dosage: ____
____

Please any allergies to latex, medications or foods and reactions: _____________________________________
____

Have you had any surgeries since we last saw you? Yes___ No___
If Yes then please list them: ____
____

Have you been diagnosed with any new medical problems since we last saw you? Yes___ NO____
If Yes then please list them: ____
____

Have you been hospitalized since we last saw you? Yes___ No___
If yes then please list them: ____
____

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Please circle at least one answer in each column below.
Have you had any problems with:

Head and Neck	**Pregnancies**	**Bones and Joints**
Decreased hearing	Are you or might be pregnant?	Arthritis or Rheumatism
Ringing in ears	None of the above	Bone weakness
Hoarseness		(Osteoporosis)
None of the above		None of the above

Cardiovascular/Pulmonary	**GI/GU**
Chest pain/angina	Indigestion/vomiting/nausea
High cholesterol/lipids	Cirrhosis/Hepatitis/Jaundice of liver
High blood pressure	Kidney stones
Heart attack/heart disease	Kidney failure/dialysis
Asthma	Enlarged prostate
Shortness of breath	None of the above
Emphysema/COPD	
None of the above	

Neurological	**Hematology**	**Endocrine**
Stroke	Anemia (low blood)	Diabetes
Seizures/Convulsions/Epilepsy	Do you bleed or bruise easily	Thyroids
Dizziness	None of the above	None of the above
Migraine headaches		
None of the above		

Skin	**Allergies**
Moles that have changed	Hives or eczema
History of fever blisters	Food allergies
None of the above	None of the above