

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: _____

Patient Information

Name _____ DOB ___/___/_____

Please circle at least one answer in each column below.

Have you had any problems with:

Head and Neck

Decreased hearing

Ringing in ears

Hoarseness

None of the above

Pregnancies

Are you or might be pregnant?

None of the above

Bones and Joints

Arthritis or Rheumatism

Bone weakness

(Osteoporosis)

None of the above

Cardiovascular/Pulmonary

Chest pain/angina

High cholesterol/lipids

High blood pressure

Heart attack/heart disease

Asthma

Shortness of breath

Emphysema/COPD

None of the above

GI/GU

Indigestion/vomiting/nausea

Cirrhosis/Hepatitis/Jaundice of liver

Kidney stones

Kidney failure/dialysis

Enlarged prostate

None of the above

Neurological

Stroke

Seizures/Convulsions/Epilepsy

Dizziness

Migraine headaches

None of the above

Hematology

Anemia (low blood)

Do you bleed or bruise easily

None of the above

Endocrine

Diabetes

Thyroids

None of the above

Skin

Moles that have changed

History of fever blisters

None of the above

Allergies

Hives or eczema

Food allergies

None of the above