PATIENT INFORMATION SHEET

Name: _____ **DOB:** _____ / _____ / _____

Today's Date: _____ / _____ / _____ **MRN:** _____

VS: BP: _____ / _____ Pulse: _____ Resp: _____ O2 Sat: _____ Temp: _____

Weight: _____ Height: _____ Pain: _____

Your regular or referring medical provider *(PCP, Ob-Gyn, etc.)***:**

Name: _____

Address / Location: _____

Do you want your office notes sent to your doctor? □ Yes □ No

Your regular pharmacy: Name & location: _____

Your compounding pharmacy *(if applicable):* _____

Your medical history *(hypothyroidism, diabetes, hypertension, etc.)***:**

_____

_____

_____

_____

_____

Allergies & sensitivities: _____

_____

_____

Previous major surgeries: _____

_____

_____

_____

Major diseases in immediate family members *(parents, siblings, children)**:***

_____

_____

Current medications & vitamins *(name, dose, how often taken)*:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Other: Marital status: _____ Occupation: _____

Alcohol use: □ Never □ Almost never □ Socially □ Daily □ More than daily

Current cigarette / cigar smoker? □ Yes □ No Packs per day: _____

If previous smoker, when did you quit? _____

Are you exposed to second hand smoke in your house? □ Yes □ No