Patient Information Sheet

This information provided will remain confidential

First Name:_____ M.I.____ Last Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Daytime Phone: _____ Insurance Carrier: _____
Date of Birth: _____ Sex: _____
Would you like child-proof containers? Yes _____ No _____
Legal guardian (if applicable): _____

Please answer the following questions to help us better assess your healthcare needs:

Do you smoke or vape? Yes _____ No _____ If so, what quantity per day? _____
Do you consume alcoholic beverages? Yes _____ No _____
Please list any medications you are currently taking (if easier, attach list from provider)
Name: _____ Strength: _____
Name: _____ Strength: _____
Name: _____ Strength: _____
Name: _____ Strength: _____
Name: _____ Strength: _____
Name: _____ Strength: _____
Please list any physicians/healthcare providers you are currently using:

_____

Please list any drug allergies you have:

_____

Please list any health problems/conditions you have/had:
Diagnosis: _____ Date of Onset: _____
Diagnosis: _____ Date of Onset: _____
Diagnosis: _____ Date of Onset: _____
Diagnosis: _____ Date of Onset: _____

Other Information (Please list any other health related information that may be of importance)_____

_____

_____

Signature: _____ Date:_____