PATIENT MEDICAL INFORMATION SHEET

Patient Name _____ DOB_____

Allergies: _____

Are you currently under medical treatment?	Y/N
Have you ever been hospitalized for any surgical operations or serious illness?	Y/N
Have you ever taken Fen Phen or Redux?	Y/N
Do you use Tobacco?	Y/N
Do you use Alcohol?	Y/N
Do you use illicit or street drugs?	Y/N
Are you Pregnant or think you may be?	Y/N
Are you taking Birth Control Pills?	Y/N
Are you Nursing?	Y/N

Do you have, or have you had, any of the following? (Please circle those that apply)

Joint replacement	Stroke	Diabetes	Kidney disease
Heart disease	Easily winded	Epilepsy/Convulsions	Hepatitis/Jaundice
Heart attack	Frequently tired	Fainting/Seizures	Liver disease
Heart murmur	Respiratory problems	Stomach problems	Thyroid problems
Cardiac pacemaker	Emphysema	Ulcers	Arthritis
Mitral valve prolapse	Asthma	Cancer	Anemia
Angina	Tuberculosis	Leukemia	Glaucoma
Chest pains	Hayfever/Allergies	Radiation therapy	Recent Weight Loss
Rheumatic fever	High blood pressure	AIDS/HIV	
Swollen ankles	Low blood pressure	Sexually transmitted diseases	
Other: _____		Other: _____	

Physician's Notes:

_____

_____

_____

_____

_____ _____

Patient Signature **Date**

Patient Name: _____ DOB: _____

Allergies: _____

Current Medications (Please list all medications, including over the counter)

Name	Dosage/frequency	Reason/Other

Preferred Pharmacy Name: _____

Address: _____

Phone Number: _____

Primary Physician Name: _____

Address: _____

Phone Number: _____

All the information I have provided is correct to the best of my knowledge.

_____ _____

Signature Date