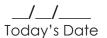
New Patient Medical Information, v. 1



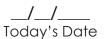


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Patient Demographics

Name		SS#		DOB		
Pharmacy Name	Pharmacy Ph	none	Pharmacy Street / City / State			
Primary Care Physician			Referring Physician			
Do you have an Advance Di	rective? 🔲 Y	es 🗆 No				
Madiagliana Di 11 11	1 1 .1	1 1	1 .	1 . 1.		
Medications Please list all m	1					
Medication	Dose/ Strength	How often do you take this medication?	Reason for taking this medication?	Who prescribed this medication for you?		
Allergies Please list all allergie	es and the reaction	on that occurred.				
Allergic to?		Describe re	action that occurred	:		
Medical/Surgical History	Please list all 1	medical conditions and nrev	rious suraeries			
	1 tease tist att 1		tous surgeries.			
Family Medical History Illness/Condition			Deceased?	Cause of Death		
Father			☐ Yes ☐ No			
Mother			☐ Yes ☐ No			
Grandparents			☐ Yes ☐ No			
Sisters/Brothers			☐ Yes ☐ No			
0.070.07.0101013			<u></u>			
Social History	Тур	e	Amount	Years Quit?		
Alcohol	, 1-					
Caffeine						
Recreational drugs						
Tobacco products						

New Patient Medical Information, v. 1





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Name	SS#	DOB

Review of S	Symptoms	Please indicate whether	you have experienced a	ny of these syr	nptoms in the	previous six mon	ths
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General	Fever/Chills			Abdomen	Indigestion/Heartburn		
	Night Sweats				Ulcers		
	Weight Loss (lbs)				Diverticulitis/Crohn's/Colitis		
	Jaundice				Constipation		
Eyes	Cataracts or Glaucoma				Gallbladder Trouble		
	Contacts or Glasses				Hernia		
	Distorted Vision				Diarrhea		
Ears	Hearing Loss/Pain/Ringing				Nausea/Vomiting		
	Dizziness or Vertigo				Change in Bowel Habits/Bloody Stool		
	Ear Infections				Vomiting Blood		
Nose	Congestion			Urinary	Kidney Stones		
	Runny Nose				Kidney Failure (Dialysis)		
	Mouth Breather				Incontinence		
	Nosebleeds				Painful or Bloody Urination		
Throat	Frequent Sore Throats				Prostate Problems		
	Difficulty Swallowing			Endocrine	Thyroid Disorder		
	Snoring				Diabetes		
	Sleep Apnea				Hormone Replacement		
	Daytime Sleepiness			Hematology	Anemia		
Dental	Dentures: Upper or Lower			Infectious	Hepatitis		
	Last Dental Visit:/ (MM/YY)			Diseases	HIV/AIDS		
	Dentist:		Skin	Lesion/Rash/Hives			
Heart	Flutter/Palpitations				Psoriasis/Eczema		
	Murmur			Psychological	Depression		
	High Blood Pressure				Mood Swings		
	Chest Pain			Nervous	Numbness		
Lungs	Bronchitis/Chronic Cough				Seizures/Convulsions		
	Asthma/Wheezing				Stroke		
	Shortness of Breath				Migraine Headaches		
	COPD/Emphysema			Muscles	Weakness of Limbs		
Breast	Lump or Cyst				Arthritis		
	Pain or Discharge			Other			
	Change in Appearance			(please list)			
	Family History of Breast/Ovarian Cancer						
Vascular	Circulation in Arms or Legs						
	Aneurysm						
	Varicose Veins						
	Swelling in Feet/Legs					-	
	Blood Clot						