PATIENT QUESTIONNAIRE

NAME_____DOB_____

HEIGHT_____WEIGHT_____SEX M F_____

MEDICATIONS TAKEN ON A REGULAR BASIS (NAME, DOSAGE AND INTERVAL)

(INCLUDE ASPIRIN, TYLENOL, MOTRIN, WEIGHT LOSS PRODUCTS AND OVER THE COUNTER MEDICATION)

MEDICATION	DOSAGE	INTERVAL
1.		
2.		
3.		

ARE YOU ALLERGIC TO ANY DRUGS? PLEASE LIST BELOW THE DRUGS TO WHICH YOU ARE ALLERGIC

1	3
2	4

PREVIOUS SURGERY

TYPE	DATE
1	
2	
3	
4	

PHARMACY TO BE USED FOR PRESCRIPTIONS

PHARMACY	ADDRESS	PHONE #	STAFF

PATIENT QUESTIONNAIRE

Page 2 **Date of Visit:** _____

Name: _____ **DOB:** _____

Reason for Visit:

Past Medical History:

Medical problems: Heart___; Diabetes____; Blood pressure___; Other____

Social History:

Do you smoke- Amount and frequency:

Drink alcohol-- Number of drinks per week:

Other: (aspirin, diet pills, etc.)

Family History:

Family members with history of ____

Cancer –

Heart problems—

Blood pressure---

Diabetes---

Cholesterol----

Other-----