Patient Information & Medical History Form

Patient Information

Full Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Address: _____

City: _____

State: _____

Zip: _____

Preferred Pharmacy

(Name & Location): _____

Occupation

Title: _____

Employer: _____

Phone number: _____

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

Reason for Visit / Chief Complaint

_____

_____

Primary Care Provider

Name: _____

Phone (if known): _____

Date of Last Visit: _____

Medical History

□ Diabetes

□ Hypertension (High Blood Pressure)
□ High Cholesterol
□ Heart Disease
□ Asthma
□ Thyroid Disorder
□ Thyroid Cancer
□ Multiple Endocrine Neoplasia (MEN)
□ PCOS
□ GERD / Acid Reflux
□ Depression / Anxiety
□ Kidney Disease
□ Liver Disease
□ Cancer (Type: _____)
□ Other: _____

Surgical History

List any prior surgeries and dates (if known):

_____

_____

Current Medications

List all prescription, over-the-counter, and supplements:

_____

_____

Allergies

List all medication/food/environmental allergies and reactions:

_____

□ No known allergies

Social History

Do you smoke or use tobacco? □ Yes □ No
If yes, how much and how often? _____
Do you drink alcohol? □ Yes □ No
If yes, how often? _____
Do you use recreational drugs? □ Yes □ No
If yes, please specify: _____

Reproductive Health (if applicable)

Are you currently pregnant? □ Yes □ No □ Not Sure

Date of Last Menstrual Period (LMP): _____

Are you using contraception? □ Yes □ No

If yes, what kind? _____

Vitals (Self-Reported for Telehealth)

Height: _____

Weight: _____

Blood Pressure (if known): _____

Heart Rate (if known): _____

Family Medical History

Father: _____

Mother: _____

Siblings: _____

Consent & Signature

I affirm that the above information is accurate to the best of my knowledge. I understand that this information is used to provide safe and appropriate medical care.

Patient Signature: _____

Date: _____