It is imperative for you to fill out this form as completely as possible. This information will be entered into the computer and you are welcome to a copy of the report upon request.

Patient's Last Name_____First_____MI__
Height_____Weight_____

Primary Care Physician_____

Requesting Physicians_____

Pharmacy Preference
(include location)_____

GOVERNMENT REQUIRED FIELDS:
Tobacco use? ◯ ◯

Flu shot? ☐ If yes, month/day/year:_____

Pneumonia vaccine? ☐ If yes month/day/year:_____

Colonoscopy? ☐ If yes month/day/year:_____

PAP Smear? ☐ If yes month/day/year:_____

Mammogram screening? ☐ If yes month/day/year:_____

PLEASE LIST ANY MEDICATIONS/DOSAGE YOU ARE CURRENTLY TAKING:

_____

_____

_____

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ◯ YES ◯ NO (if yes, please list below)

_____

_____

_____

List any surgeries you have had (including date):

_____

_____

_____