

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:**

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

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List any surgeries you have had (including date):

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