Patient Information

Name: _____

Address: _____Apt#_____

City: _____

State: _____Zip: _____

Sex: _____ Date of Birth: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____
(Used for newsletters, online consults, medication refills)

Preferred Contact Method:

Cell Home Phone Work Phone Email

Preferred Language: _____

Employer: _____

Social Security #: _____-_____-_____
(Used for test results and orders)

Relationship Status: Married, Single, Divorced, Other

Emergency Contact: _____

Phone number: _____

Relationship: _____

List of Current Medications:

Medication	Mg/Dose	Frequency

Drug Allergies(include reaction)

_____

Non-drug Allergies(include reaction)

_____

Pharmacy Name & Location:

_____

How did you hear about us:

- ☐ Billboard
- ☐ Bridal Show
- ☐ Boat Show
- ☐ Coupon Offer:_____
- ☐ Dallas Voice
- ☐ Door Hanger
- ☐ Fire Department:_____
- ☐ Good Morning Texas
- ☑ GYM:_____
- ☑ Health Fair
- ☐ Internet Search
- ☐ Living FIT
- ☐ Observer
- ☐ Infomercial
- ☐ Website
- ☐ Wellness Expo
- ☐ Yelp
- ☐ Other:_____

	Yes	Date		Yes	Date		Yes	Date
AIDS/HIV			Gout			Pancreatitis		
Anemia			Heart Abnormalities (specify)			Peptic Ulcer		
Anxiety			Heart Attack (Myocardial Infarction)			Pneumonia		
Arthritis			Hemorrhoids			Psychiatric Problems		
Asthma			Hepatitis			Pulmonary Fibrosis		
Back Problems			Hernia (specify)			Rheumatic Fever		
Bleeding Disorder/Blood Clots			High Cholesterol			Rheumatoid Arthritis		
Bladder Infection			Hypertension			Seizures		
Cancer (Breast, Colon, Lung, Skin, Prostate,			Hyperthyroid			Sexually Transmitted Disease		
Cataract			Hypothyroid			Skin Disease		
Colitis			Kidney Stones			Sleep Apnea		
Congestive Heart Failure			Liver Disease			Stroke		
Coronary Heart Disease			Lymphoma			Other:		
COPD			Lupus Erythematosus					
Depression			Migraines					
Diabetes			Multiple Sclerosis					
Gallstones			Osteoarthritis					
GERD			Osteoporosis/ Osteopenia					
Glaucoma			Palpitation					

Social History

Tobacco Use: Yes/No - Type:
_____

Alcohol Use: Yes/No - How Ofter
_____

Exercise: Yes/No - How Often:
_____

Routine Health Screening

(Most recent Dates)

Colonoscopy: _____

Mammogram: _____

Pap Smear:_____

Bone Density:_____

Tetanus Booster:_____

_____
Patient Name (Signature) Date

Total Med Solutions, LLC