Name:
DOB:
Chart:
Age:
Date:

TODAY'S DATE: _____

NAME: _____ **DATE OF BIRTH:** _____

PATIENT MEDICATION LIST:

MEDICATION	DOSE	REASON FOR USE

ALLERGIES TO MEDICATION: _____

_____

HEIGHT: _____

WEIGHT: _____

DO YOU DRINK ALCOHOL? ☐ Y ☐ N **HOW MUCH PER WEEK?** _____
DO YOU SMOKE? ☐ Y ☐ N **HOW MANY PACKS PER WEEK?** _____
HAVE YOU EVER SMOKED? ☐ Y ☐ N **HOW LONG AGO?** _____
DO YOU EXERCISE? ☐ Y ☐ N **HOW OFTEN?** _____

_____ _____
Patient Signature **Date**