

MedicationXpert.com
Patient Confidential Information

Please fill in all blanks....

Name: _____

Date of birth: ____ / ____ / ____

Address: _____

City: _____ State: _____ Zip: _____

Sex: _____ Ethnicity: _____ Height: _____ Weight: _____

Phone: (day) (____) _____ - _____ (night) (____) _____ - _____

FAX: (____) _____ - _____

Health Conditions (Diagnosis) listed in your health record by your doctor:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

List the *health problems* that you think you have and are not listed by your doctor:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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List Allergies or any *idiosyncrasies* you have (be complete):

1. _____
2. _____
3. _____
4. _____

Primary Physician:

Name: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Approximate date of last visit to the doctor: _____

Reason for the visit:

List other doctors you see:

1. _____

What reason? _____

Outcome of visit: _____

2. _____

What reason? _____

Outcome of visit: _____

3. _____

What reason? _____

Outcome of visit: _____

4. _____

What reason? _____

Outcome of visit: _____

5. _____

What reason? _____

Outcome of visit: _____

6. _____

What reason? _____

Outcome of visit: _____

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Primary Pharmacy used:

1. _____
Phone: _____
Address: _____
City: _____ State: _____ Zip: _____