

Patient Information		
Name		DOB (MM/DD/YYYY):
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____	Preferred Pronouns: <input type="checkbox"/> He/Him <input type="checkbox"/> She/Her <input type="checkbox"/> They/Them <input type="checkbox"/> Other: _____	
Address:		City
State:	Zip:	Email:
Phone:	Preferred Contact Method: <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Text	
Emergency Contact Name:		Phone:
Relationship to Patient		
Insurance Information (if applicable)		
Provider:	Policy number:	
Group Number:	Policyholder Name	
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____		
Reason for Visit		
Primary Reason for Visit:		
How long have you had this issue?	Have you been treated for this before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical History Summary		
Do you have any of the following conditions? (Check all that apply) <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Stroke <input type="checkbox"/> Other: _____		
Are you currently taking any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list medications:	
Do you have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list allergies:	
Have you had any surgeries or hospitalizations? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list procedures and dates:	
Lifestyle & Social History		
Do you smoke or use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former Smoker		
Do you consume alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Occasionally		
Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Occupation:		
Do you have any concerns about access to healthcare, transportation, or financial barriers? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please describe: _____		
Pharmacy Information		
Preferred Pharmacy Name:	Phone Number:	
Address:		
Consent & Signature		
I confirm that the information provided is accurate to the best of my knowledge.		
Signature:		Date: