Today's Date: ___________________

Name: ____ Date of Birth: ____________________

Patient Medication List

Medication	Dose	Reason for Use

Allergies to Medication: ____

____

Height: _________________

Weight:_________________

Do you drink alcohol? ( ) Yes ( ) No How much per week?___________________

Do you smoke? ( ) Yes ( ) No How many packs per week? _____________

Have you ever smoked? ( ) Yes ( ) No How long ago? _______________________

Do you exercise? ( ) Yes ( ) No How often? __________________________

____

Patient Signature **Date**