Print Form

LOURDES

New Patient Information Sheet

Name: _____ **DOB:** _____

Allergies: _____

_____

Medical History: _____

_____

_____

Surgical History: _____

_____

_____

Primary Language Spoken/ Cultural Considerations: _____

_____

Current/History of Drug/Alcohol Use: _____

_____

Current/History of Smoking: _____

_____

Current Diet: _____

_____

BMI (by physician if indicated): _____

Medications: See med sheet – **Include Alternate Therapies/Over the Counter Medications**

Ht: _____ **Wt:**_____ **B/P:** _____ **P:**_____ **R:** _____ **T:** _____ **Pain Scale Rating:** _____

Reason for today's visit: _____

_____

_____

_____

_____

Reviewed by: _____ **Date / Time:** _____