MEDICATION LIST/SOCIAL HISTORY

131 W. Sunset Rd, Suite 101
San Antonio, TX 78209
Office: 210-255-8447
Fax: (210) 255-8446

Date:_____

Name:_____ Date of Birth:_____

GENERAL INFORMATION Height: _____ Weight: _____ Age: _____

Reason for your visit: _____

_____

Employment status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Homemaker ☐ Other (specify):_____

What is your occupation? _____

Daily activity level: ☐ Active ☐ Moderately active ☐ Sedentary

Have you ever or do you currently:

☐Smoke Frequency:_____ How long?_____
☐Use alcohol Frequency:_____ How long?_____
☐Use drugs Frequency:_____ How long?_____

Date (Year) of last of the:

Flu shot: _____

Pneumonia shot: _____

Shingles shot: _____

ALLERGIES

Do you have any allergies to include medications, food, iodine, shellfish? Please list what type of reaction you had. _____

_____

_____

MEDICATIONS

(Please include over the counter medications and herbal supplements)

1.	Medication	Dose & Frequency	Reason
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Please continue on the back side if more room is needed.

Preferred Pharmacy: _____

Pharmacy phone number: _____

Pharmacy address: _____