Care Memphis Clinic, PLLC

PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: M F

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose	How long taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Preferred Pharmacy:_____Location:_____

Phone:_____

Provider initials _____