



Patient Information Form

Name: _____ Date: _____
 Date of birth: _____ PHN #: _____
 Age: _____ Height: _____ Weight: _____ BMI: _____
 Phone #: _____ Caregiver (if appropriate): _____
 Address: _____

Enrolled with MSP? Yes No If Yes, please specify: _____
 Registered with PharmaCare? Yes No _____
 Third-Party Insurance? Yes No _____

Health Information

Family Physician: _____ Pharmacist: _____
 Other Health Professionals: _____
 Date of Last Physical: _____
 Medical & Surgical History: _____

 Allergies(specify): _____

Background Information/Lifestyle Factors

1. Regular exercise? Yes No
 2. Special Dietary Needs? Yes No
 Specify: _____
 3. Yearly Flu Shot? Yes No
 4. Smoking? Yes No
 Quantity: _____
 5. Alcohol consumption? Yes No
 Quantity: _____
 Do you administer all the medications yourself?
 Yes No
 If no, please specify: _____

 Do you have any difficulty swallowing?
 Yes No

Consent

Patient has received information on and consented to the review process? Yes No
 Patient has agreed that information may be shared with their doctor? Yes No

Comments:

