Last Name:		First Name:		Date:
M / F	DOB (d/m/y):	Age:	Wt: Kg / Lbs	Ht: cm / ft in
Health Insurance:			Occupation:	Living Arrangements:
Address:			Tel (h):	Tel (c):
			Allergies:	
PMH:				

Current DTPs:	Goal:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Medications (Rx):	Indication:	Start/Stop	Response:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
OTC / Natural / etc.			
1.			
2.			
3.			
4.			
5.			
Smoking tobacco:	Alcohol:	Recreational:	

Attitude towards taking meds./cultural, religious, ethics issues:

Care Plan/Progress Notes: