Rontal Clinic

PATIENT HEALTH INFORMATION

In order for us to obtain a complete medical history it is important for you to fill out this form as completely as possible. This information will be entered into your patient file for your doctor to know and consider as he cares for your health needs.

Your Full Name: _____ Birth Date: _____

Primary Care/Family Physician Name: _____

Phone #: _____

What is **the main reason** you are here to see our physician today? _____

_____

****Pharmacy Name: _____Phone # _____**

****Pharmacy Address (cross streets): _____**

Are you taking any medications now, if yes list all medications below (prescribed, over the counter or herbal medications).

Name of Medication	Dosage (mg)	How Often Do You Take It

ARE YOU ALLERGIC TO ANY MEDICATIONS? If yes list below

Name of Medication	What Type of Reaction Do You Have

Patient Signature: _____ Date: _____

Office Use Only:

Blood Pressure**: _____ Weight**: **_____ Height**: _____