Patient Information

Name John Doe | DOB *(MM/DD/YYYY):* 01/15/1985

Gender: ☒ Male ☐ Female ☐ Other: _____ | Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____

Address: 123 Main St, Springfield, IL 62701 | City Springfield

State: IL | Zip: 62701 | Phone: (555) 123-4567

Email: johndoe@email.com | Preferred Contact Method: ☒ Phone ☐ Email ☐ Text

Emergency Contact Name: Jane Doe | Phone: (555) 987-6543

Relationship to Patient Spouse

Insurance Information *(if applicable)*

Provider: Blue Cross Blue Shield | Policy number: 123456789

Group Number: Group 98765 | Policyholder Name John Doe

Relationship to Patient: ☒ Self ☐ Spouse ☐ Parent ☐ Other: _____

Reason for Visit Annual Checkup

Primary Reason for Visit: Occasional dizziness in the morning

How long have you had this issue?
last 3 weeks

Have you been treated for this before? ☐ Yes ☐ No

Medical History Summary

Do you have any of the following conditions? (Check all that apply) ☒ Diabetes ☒ Hypertension ☐ Heart Disease ☐ Asthma ☐ Cancer ☐ Stroke ☐ Other: _____

Are you currently taking any medications? ☒ Yes ☐ No

If yes, list medications:
Metformin 500mg (once daily)
Lisinopril 10mg (once daily)

Do you have any allergies? ☒ Yes ☐ No

If yes, list allergies:
Penicillin

Have you had any surgeries or hospitalizations? ☒ Yes ☐ No

If yes, list procedures and dates:
Appendectomy (2010)

Lifestyle & Social History

Do you smoke or use tobacco products? ☒ Yes ☐ No ☐ Former Smoker

Do you consume alcohol? ☒ Yes ☐ No ☐ Occasionally

Do you use recreational drugs? ☐ Yes ☒ No

Occupation: software engineer

Do you have any concerns about access to healthcare, transportation, or financial barriers? ☐ Yes ☐ No

If yes, please describe: _____

Pharmacy Information CVS Springfield

Preferred Pharmacy Name: CVS | Phone Number: (555) 123-8888

Address: 567 Main St, Springfield, IL 62701

Consent & Signature John Doe | 02/15/2025

I confirm that the information provided is accurate to the best of my knowledge.

Signature: John Doe | Date: 02/15/2025