



meadowsweet

PATIENT INFORMATION FORM (confidential)

Name _____ Date _____

Address _____¹ Phone () _____-

City _____ State _____ ZIP _____

E-mail address _____

Date of Birth _____ Age _____ Sex: Male Female

Health History

Current medications/drugs/supplements being taken: (use separate sheet if needed)

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Allergies to food/medication? No If yes, list: _____

List of all medical diagnoses

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Are you pregnant or potentially pregnant? Yes No Potentially Are you nursing? Yes No

Race (optional): _____ Ethnicity (optional): Hispanic Non-Hispanic

Is there any other information you would like us to know about you or your particular needs?

Authorizations

May we contact you via text messaging for appointment reminders and informal correspondence? Yes No

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used to help determine appropriate and healthful treatment. If there is any change in my medical status, I will inform the provider.

I understand that I will be receiving treatment by Meadowsweet Medical

Signature of Patient or Authorized Individual: _____ Date: _____