

Patient Health Survey

Date Prepared:		Street Address:	
Your Name:		City, State & Zip:	
Date of Birth:		Home #:	
Email Address:		Work #:	
Other:		Cell #:	

#	Medication Name & Dosage	Why do I take it	OTC / RX	# @ time	# of times a Day	Comments
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

#	Type of Surgery	Date of Surgery	Medical Conditions
1			
2			
3			
4			
5			
6			
7			

#	Doctor's Name	Type Doctor	Phone #	Detailed Info (Address, etc.)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				