



Patient Information Form

Name:				Date:	
Date of birth:		PHN	PHN #:		
Age: Height	: Weight:		ight:	BMI:	
Address:					
Enrolled with MSP?	Yes□	No□	If Yes, please	specify:	
Registered with PharmaCare?	Yes□	No□			
Third-Party Insurance?	Yes□				
Health Information					
	n: Pharmacist:				
Other Health Professionals:					
Medical & Surgical History:					
Background Information/	Lifestyl	e Factors	Consent		
1. Regular exercise?	Yes □	No □	Patient has re	eceived information on and consented	
2. Special Dietary Needs?	Yes□	No □	to the review process? Yes ☐ No ☐		
Specify:			Patient has a with their do	greed that information may be shared ctor? Yes □ No □	
3. Yearly Flu Shot?	Yes □	No □	with their doctor.		
4. Smoking?	Yes □	No □	_		
Quantity:			Comments	<u> </u>	
5. Alcohol consumption?	Yes□	No □	<u></u>		
Quantity:			<u></u>		
Do you administer all the med	ications	yourself?			
	Yes□	No □	<u> </u>		
If no, please specify:					
Do you have any difficulty swa	llowing	?			
	Yes□	No □			