MEQUON WELLNESS CENTER

PATIENT INFORMATION

First & Last Name: *(please provide your legal name as it appears on your driver's license)*

_____

Date of Birth: _____

Home Address:

_____

_____

Email: *(we use this to set up your online medical records account)*

_____

Phone: _____

Are you allergic to any medications? *(if so, please list the medications)*

_____

_____

Are you currently taking any over the counter or prescription medications? If so, please list the medication(s), the dose (mg) and how often you take the medication.

_____

_____

_____

_____

_____

_____

_____

Should we need to call in a medication for you, what pharmacy do you prefer to use. *(please list the name of the pharmacy and the town that it is in)*

_____

_____

Mequon Wellness Center LLC
11649 N Port Washington Rd, Ste 114
Mequon, WI 53092

MEQUON WELLNESS CENTER

Past Medical History: _____

_____

_____

_____

Past Surgical History: _____

_____

_____

_____

Do you smoke? _____

How many per day? _____

Do you drink? _____

How many drinks per day or week? _____

Any significant family history: _____
(From Mom, Dad, or Siblings)

_____

_____

_____

_____

_____

_____