Face Sheet Template

Name ______________________________ **D.O.B.** ______________________________

Address ____

______________________________ **Phone #** ______________________________

Primary Care Doctor's Name/Contact Info ______________________________

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Past Medical History (include dates, diagnoses)

Past Surgical History (include dates, diagnoses)

Current Medications (include over-the-counter and supplements)

DRUG	PURPOSE	STRENGTH	FREQUENCY	START DATE	SIDE EFFECTS

Past Medications (include over-the-counter and supplements)

DRUG	PURPOSE	STRENGTH	FREQUENCY	END DATE	SIDE EFFECTS

History of Present Illness (timetable of events – include symptom onset, tests)