premier
allergy & asthma
LIFE IN BLOOM

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Please answer all questions to the best of your knowledge.
Completion of this intake information is an essential part of your medical care

MEDICATIONS YOU ARE CURRENTLY TAKING:

Prescribed Medications:	Route (i.e. by mouth, inhalation, injection)	Dosage	Frequency (i.e. once a day as needed)

Over the Counter Medications:

Herbal, Homeopathic, Supplements:

If Signed by the Patient:

_____
Signature

_____
Printed Name

_____
Date

If Signed by the Authorized Representative:

_____
Signature

_____
Printed name

_____
Relationship to Patient

_____
Date

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