Institute for Progressive Medicine

4 Hughes #175, Irvine, CA 92618 Tel: (949) 600-5100 Fax: (949) 600-5101
iprogressivemed.com

Medical Doctor Return Patient Packet

(Please Print Clearly)

Today's Date: ____/____/____

Name: _____ Birth Date: ____/____/____
(First, Middle Initial and Last)

Primary Reason for Visit: _____

Race: _____ Ethnicity: _____ Height: _____

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Has your insurance changed since your last visit? ☐ Yes ☐ No

Has your contact information changed since your last visit? ☐ Yes ☐ No
If so, you are responsible for providing the information to IPM

Mailing Address: _____

City: _____State: ____ Zip: _____ Tel: (_____) _____-_____

Who may we contact in the case of an emergency?

Name: _____ Tel: (_____) _____-_____

Relationship: _____

Current Medications:

Name of prescription:	Strength and Dosage:	How often per day:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Drug Allergies: please check or list all drugs and the type of reaction:

☐ I am not allergic to any medications

☐ Penicillin Reaction_____ ☐ Codeine Reaction_____

☐ Sulfa Reaction_____ ☐ Other Reaction_____

Would you like to be tested for HIV? ☐ Yes ☐ No

Smoking and Alcohol History:

Do you smoke now? ☐ Yes ☐ No Have you smoked in the past? ☐ Yes ☐ No

For how many years did you smoke? _____ When did you quit: _____

Do you use other tobacco products: ☐ Yes ☐ No

How much alcohol do you drink: ☐ None ☐ 1-7 Drinks/week ☐ 8-14 Drinks/week

☐ More than 14/week ☐ Specify: _____

MY SIGNATURE BELOW CONSTITUTES CONSENT TO MEDICAL SERVICES:
I consent to medical evaluation and treatment by The Institute for Progressive Medicine. I understand that the Institute for Progressive Medicine may recommend various methods to help me regain my health and those methods will be discussed.

_____

Patient Name (Please print) **Patient Signature** **Date**