

**ESTABLISHED RECHECK/PROBLEM INFORMATION FORM**

**\*\*Room #** \_\_\_\_\_

**NAME:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
(Please print)

**Local Pharmacy Name:** \_\_\_\_\_ **Pharmacy phone:** \_\_\_\_\_

**Mail Order Pharmacy:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**ALLERGIES: Drug:** \_\_\_\_\_ **Food:** \_\_\_\_\_ **LATEX ALLERGY: Yes** \_\_\_ **No** \_\_\_

**Are you currently sexually active? Yes** \_\_\_ **No** \_\_\_

**What are you doing to prevent pregnancy?**

Birth control pill \_\_\_\_\_, Condoms \_\_\_\_\_, IUD \_\_\_\_\_, Nexplanon, Vasectomy \_\_\_\_\_, Tubal ligation \_\_\_\_\_,  
Abstinence \_\_\_\_\_, Menopause \_\_\_\_\_, Same sex partner \_\_\_\_\_  
other (please explain) \_\_\_\_\_

**Current Tobacco Use: Yes** \_\_\_ **No** \_\_\_

**Vaping: Yes** \_\_\_ **No** \_\_\_

**REASON FOR TODAY'S VISIT:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**\*Office Use Only\***

**Vital Signs: HT** \_\_\_\_\_ **WT** \_\_\_\_\_ **BP** \_\_\_\_\_ / \_\_\_\_\_

**G** \_\_\_\_\_ **P** \_\_\_\_\_

**LMP** \_\_\_\_\_

**BMI:** \_\_\_\_\_

**Smoker: Current / Previous / Never Vaping: Yes or No**