



# DR LORI PUSKAR

Nutritional Medicine Specialist

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## NEW ONLINE PATIENT INFORMATION FORM

Please print clearly:

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Primary Phone \_\_\_\_\_ Please Circle (mobile/home/work/other)

E-mail address: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender: M/F Height \_\_\_\_\_ Weight \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

Occupation \_\_\_\_\_

Please list your Health Symptoms/Problems/Concerns/Complaints: (in priority order)

- |    |     |
|----|-----|
| 1. | 6.  |
| 2. | 7.  |
| 3. | 8.  |
| 4. | 9.  |
| 5. | 10. |

Current medications/drugs being taken:

Are you currently under the care of a physician or other health care professionals? (If yes, please give name/date of last visit):

List any major illnesses, diagnoses, accidents, or surgeries (with approx. dates):

All of the above is true to the best of my knowledge:

Print (Patient Name)	Patient Sign (Parent/Guardian, if under 18)	Date
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