Patient Information

Name: Jane Doe | DOB (MM/DD/YYYY): 05/12/80

Gender: ☐ Male ☑ Female ☐ Other: _____ | Preferred Pronouns: ☐ He/Him ☑ She/Her ☐ They/Them ☐ Other: _____

Address: ABC, London, UK | City: London

State: | Zip: NS 0AB | Email: abc@email.com

Phone: | Preferred Contact Method: ☐ Phone ☐ Email ☐ Text

Emergency Contact Name: John Doe | Phone: 01274 5678

Relationship to Patient

Insurance Information *(if applicable)*

Provider: LTH Provider | Policy number: ABC x 0123

Group Number: LS | Policyholder Name: Jane Doe

Relationship to Patient: ☐ Self ☑ Spouse ☐ Parent ☐ Other: _____

Reason for Visit

Primary Reason for Visit: Broken leg

How long have you had this issue? 1 day | Have you been treated for this before? ☐ Yes ☒ No

Medical History Summary

Do you have any of the following conditions? (Check all that apply) ☒ Diabetes ☐ Hypertension ☒ Heart Disease ☐ Asthma ☐ Cancer ☐ Stroke ☐ Other: _____

Are you currently taking any medications? ☒ Yes ☐ No | If yes, list medications: ACE inhibitors

Do you have any allergies? ☐ Yes ☑ No | If yes, list allergies:

Have you had any surgeries or hospitalizations? ☐ Yes ☒ No | If yes, list procedures and dates:

Lifestyle & Social History

Do you smoke or use tobacco products? ☐ Yes ☒ No ☐ Former Smoker

Do you consume alcohol? ☒ Yes ☐ No ☐ Occasionally

Do you use recreational drugs? ☐ Yes ☒ No

Occupation: Worker

Do you have any concerns about access to healthcare, transportation, or financial barriers? ☐ Yes ☒ No

If yes, please describe: _____

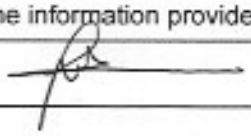
Pharmacy Information

Preferred Pharmacy Name: ABC Pharmacy | Phone Number: 0556 579

Address:

Consent & Signature

I confirm that the information provided is accurate to the best of my knowledge.

Signature:  | Date: 10/10/25