

Patient Demographic Sheet

My name is _____ (name).

Weight. _____ (lbs) Height. _____ (ft/in)

I am a _____ (age) year-old _____ (race/ethnicity)
_____ (gender).

I have _____ (no, or some-make up some) drug
allergies.

My doctor is Dr. _____ (name).

I use _____ (pharmacy) pharmacy.

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