

Barbara A. Hrach, MD, FACP
1824 State Street
Santa Barbara, CA 93101
www.docrok.com

Patient Health Questionnaire

Please Print

Dr. Hrach is dedicated to providing all her patients with compassionate and comprehensive care. In order for her to accomplish this, it is imperative that all of our patients provide us with a complete and current list of all their medications. We understand that you may not have one readily handy at this time of this visit. Please feel free to take this form home and bring it back completed at your earliest convenience.

Thank You

Current Medications List:

Name: _____	Dosage: _____	Times Taken Daily: _____
Name: _____	Dosage: _____	Times Taken Daily: _____
Name: _____	Dosage: _____	Times Taken Daily: _____
Name: _____	Dosage: _____	Times Taken Daily: _____
Name: _____	Dosage: _____	Times Taken Daily: _____
Name: _____	Dosage: _____	Times Taken Daily: _____
Name: _____	Dosage: _____	Times Taken Daily: _____
Name: _____	Dosage: _____	Times Taken Daily: _____

Patient Allergy Information:

Medication Allergies:

1. Name: _____	Reaction: _____
2. Name: _____	Reaction: _____
3. Name: _____	Reaction: _____

In order for our office to expedite filling and refilling prescriptions ordered by Dr. Hrach, we are asking all of our patients to please fill out their "preferred" pharmacy information. We will fill all Dr. Hrach's prescription orders at this pharmacy unless requested otherwise by our patients.

Thank You

Pharmacy Information:

Name: _____	Zip Code: _____
Address: _____	
Phone: _____	Fax: _____

Patient Name: _____ **Date:** _____
