OVER-THE-COUNTER PROBIOTIC DISPENSING

PATIENT INFORMATION *(Please print clearly)*

Last Name:	**First Name:**	**D.O.B.:**	**Age:**	**Gender:**	**Height:**	**Weight:**
Home Address:			Contact Phone:			
City:			State:		Zip:	
Primary Care Physician:			Physician Phone:			
Physician Address:			Physician Fax #:			
Please state any past medical history and chronic conditions:						
Current medications:						
Allergies (please state reaction that occurs when exposed to the allergen):						
Please indicate the reason for probiotic therapy:						

SCREENING QUESTIONNAIRE

	Yes	**No**	**Don't Know**
Do you currently have a condition such as cancer, leukemia, or HIV/AIDS that weakens your immune system?	☐	☐	☐
Are you currently taking cortisone, prednisone, other steroids, anticancer drugs or had any radiation treatment?	☐	☐	☐