

Restorative Health Care, P.C.

Dr. Heather Wisniewski

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Patient Profile Sheet

Patient Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Please circle best number to reach you at:

Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email Address:** _____

SS#: _____ **Date of Birth:** _____

Sex: Male Female **Marital Status:** Married Single Divorced Widowed

Occupation: _____

Employer: _____ **Employer Phone:** _____

Nearest Relative: _____ **Phone:** _____

Referred by: _____

Have you sought care for a health condition in the past year? yes no

If yes, what condition? _____

When did your symptoms appear? _____

Is this condition getting progressively worse? yes no unknown

List any doctors you have seen for your present condition: _____

What treatment was administered? _____

List any medications you are currently taking:
