

PATIENT HISTORY All information is held strictly confidential and is released only with your consent. Last Name ΜI DOB Male Female Please circle gender classification. Email Address ILLNESS / INJURY (Please check. Use space below to describe if needed.) For how long? For how long? Yes No Yes No High Blood Pressure Headache Diabetes Thyroid Diseases High Cholesterol Lung Problems/Asthma Heart Attack Stomach Ulcers Stroke Colon Diseases Abdominal Bleeding Cancer Gall Stones Hepatitis Broken Bones (List) Kidney Stones Skin Diseases Other(s) Total # of Pregnancies # of Abortions # of Miscarriages Describe Here **SURGERIES** None Year Name of Surgery Reasons for Surgery Have you ever had a blood transfusion? Yes (If Yes please specify date.) No Do you currently use tobacco? Yes (Amount) No Have you ever used tobacco? Yes (Year Quit) No Yes (Amount) Do you drink alcohol? No Have you ever used alcohol regularly? Yes (Year Quit) No List Hospital Admissions: ILLNESS IN YOUR FAMILY Father's Side Mother's Side MEDICATIONS (Please list all drugs you are taking.) Drugs Drugs Dosage Dosage PHARMACY (Please list pharmacy where you would like your prescription(s) sent.) Name Address Phone # ALLERGIES (Please list DRUG name and reaction.) None Medication Reaction Medication Reaction The above information is true and accurate.

Patient Signature (Parent/Guardian if Minor)

Print Name Signature Date