PATIENT INFORMATION/MEDICAL HISTORY

Name:_______________________________________ Date:______________ Age:________

Address:____
Street City State Zip Code

Phone: Home:___________________ Work:_________________Cell:_________________

Date of Birth:_______________ Marital Status:_________ SS#:_____________________

Employer:_____________________________________ Occupation:__________________

Emergency Contact:____________________________ Relationship:_________________
Phone: Home:__________________ Work:________________ Cell:_____________

Health History

Medication (prescription and over the counter; vitamins, herbal medications)

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Allergies:____

Surgeries/Dates:____
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Have a History of?

__Heart Disease __Mental Disease __Neuro-muscular Disease
__Excessive Bleeding __Auto-immune Disorders __Diabetes
__High Blood Pressure __Liver Disease __Cold Sores/Fever Blisters
__Other
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Are you? Pregnant_______ Nursing______

Do you? Smoke_____ Drink Alcohol______ Amount per day______________________

The above information is true and accurate to the best of my knowledge.

____ ___________________
Patient Signature Date

Address and phone number of practitioner________________________
Name of supervising MD (if applicable)__________________________
Name of medical professional providing services____________________