



PATIENT INFORMATION/MEDICAL HISTORY

Name: _____ Date: _____ Age: _____

Address: _____
Street City State Zip Code

Phone: Home: _____ Work: _____ Cell: _____

Date of Birth: _____ Email: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Phone: Home: _____ Work: _____ Cell: _____

Health History

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

Allergies: _____

Surgeries/Dates: _____

Have a History of?

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Disease | <input type="checkbox"/> Neuro-muscular Disease |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Auto-immune Disorders | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Cold Sores/Fever Blisters |
| <input type="checkbox"/> Other | | |

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