PATIENT INFORMATION / MEDICAL HISTORY

Name: _____ Date of Birth: _____

Address: _____

*Phone #: _____ Cell Home Work (circle type)

E-Mail: _____ Last 4 digits of SS#: _____

Marital Status: _____ Spouse Name: _____

Employer: _____ Occupation: _____

- Emergency Contact: _____ Relationship: _____

Emergency Contact Phone #: _____ or _____

HEALTH HISTORY

Medications including prescriptions, over the counter, vitamins and herbal products:

_____

_____

Allergies: _____

Surgeries + Dates: _____

_____

Have a history of (Please check all that apply):

___ Heart Disease	___ Mental Disease	___ Neuro-Muscular Disease
___ Diabetes	___ Excessive Bleeding	___ Auto-Immune Disorder
___ Liver Disease	___ High Blood Pressure	___ Cold Sores/Fever Blisters

Other: _____

Are you: Pregnant? _____ Nursing? _____

Do you: Smoke? _____ Drink Alcohol? _____ If yes, amount per day: _____

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

_____ _____

Patient Signature **Date**