Patient Information/Medical History

Date: ____________________

Name: ____

Address: ____

City:____State:____________Zip: __________________

Cell Phone #:______________________________________Alternate Phone#: _______________________________________

Email Address: ____

**Do you wish to receive emails or texts from this office regarding special promotions from the practice or product manufacturers on injectables? No:_______ Yes ______

Date of Birth:_____________________________Age:__________Sex: _________

Marital Status:____________________________Name of Spouse: ____

Occupation/Employer: ____

In case of emergency, contact:____Cell Phone #:_________________________

Health Questionnaire:

YOUR HISTORY—Check All Current or Past Medical Conditions:

- ☐ Allergies
- ☐ Autoimmune Disease
- ☐ Bladder/Kidney
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema/Skin Issues
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Headaches
- ☐ Heart Disease
- ☐ Herpes or Cold Sores
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Neuromuscular Disease/Stroke
- ☐ Sinus Infection
- ☐ Swallowing Issues
- ☐ Thyroid Disorder
- ☐ TMJ/Jaw Dysfunction
- ☐ Other: ________________ ______________________ ______________________

List Any Additional Concerns/Illnesses Not Mentioned Above:

____

Are you **Pregnant?_________**Nursing?**____________

Surgery/Hospitalizations	Reason	Year

List Current Prescription Medications (w/n the last 2 wks)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Current Supplements, Vitamins or Over-The-Counter Items; Including ADVIL, MOTRIN, ASPIRIN or Alleve:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

List known Allergies to either Food or Drugs:

____

Circle the Items That You Use and Indicate How Much and How Often:

Caffeine:______________________________ Alcohol: ______________________________

Cigarettes:______________________________ Illicit Drugs: ______________________________

I AGREE THAT THE ABOVE INFORMATION IS CORRECT AND CURRENT TO THE BEST OF MY KNOWLEDGE.

Signature:______________________________ Print Name: ______________________________

Date: ____________________