

Are you allergic to any medications? Yes / No

If "Yes", please provide name of medication (s) _____

Are you currently taking any medication, prescription and/or non-prescription? Yes / No

If "Yes" provide the information below

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Do you use any blood "thinners" such as Coumadin or aspirin? Yes / No (List)

Do you use any herbal or "alternative" medications or supplements? Yes / No (List)

Do you use any type of "diet" pills? Yes / No (List) _____

Are you currently pregnant or nursing? Yes / No

Have you had any surgeries? Yes / No

If "Yes", provide the details below:

Surgery: _____ Year of Surgery: _____

Surgery: _____ Year of Surgery: _____

Surgery: _____ Year of Surgery: _____

Surgery: _____ Year of Surgery: _____

Thank you for your assistance!

For office use only:

Reviewed: _____

Date: _____

_____ M.D.

Date: _____