PATIENT INFORMATION

NAME_____TEL_____ D.O.B. _____

ADDRESS_____CITY/STATE_____ZIP_____

EMAIL ADDRESS _____

MEDICATIONS _____

ALLERGIES _____

WOMEN: ARE YOU PREGNANT ? YES / NO ARE YOU BREASTFEEDING ? YES / NO

PHYSICIAN' S NAME: _____

CIRCLE ANY OF THE FOLLOWING ILLNESSES YOU HAVE OR HAVE EVER HAD IN THE PAST:

MYASTHENIA GRAVIS HEPATITIS EYE DISEASE AUTOIMMUNE DISEASE VISION PROBLEMS

NUMBNESS MUSCLE WEAKNESS EATON LAMBERT DISORDER ALS (AMYOTROPHIC LATERAL SCLEROSIS)

EXPLAIN: _____

DO YOU CURRENTLY HAVE A FEVER? YES / NO

PREVIOUS HOSPITALIZATIONS / SURGERIES: _____

I UNDERSTAND THE INFORMATION ON THIS FORM IS ESSENTIAL TO DETERMINE MY MEDICAL AND COSMATIC NEEDS AND THE PROVISION OF TREATMENT.
I UNDERSTAND THAT IF ANY CHANGES OCCUR IN MY MEDICAL HISTORY / HEALTH, I WILL REPORT IT TO THE OFFICE / DOCTOR AS SOON AS POSSIBLE.
I HAVE READ AND UNDERSTAND THE ABOVE MEDICAL QUESTIONNAIRE. I ACKNOWLEDGE THAT ALL ANSWERS HAVE BEEN RECORDED TRUTHFULLY AND WILL NOT HOLD ANY STAFF MEMBERS RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION IF THIS FORM.

PATIENT SIGNATURE_____ DATE_____