

Please complete the following questionnaire as this will help us properly address the issues important to your health:

Please list the purpose of your visit: _____

Present Health Concerns (i.e. pacemaker, difibulator, etc.): _____

1. MEDICAL HISTORY

Are you presently receiving medical treatment for any conditions? _____yes _____no

If yes please list condition(s)

CONDITION	HOW LONG

2. MEDICATIONS

Please list any medications you take regularly. Prescription, non-prescription, vitamins, home remedies, birth control pills, and herbs **(PLEASE INCLUDE ASPRIN)**:

Medication	Times per day	How long taken

3. Allergies

Are you allergic to any medications? (If yes, please list below)

Allergic to: