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Please take a few moments to answer the following questions. All information is confidential. Thank you for your time.

Name _____ Date of Birth _____ Age _____

Male Female

Hand Dominance Right Left

Reason for today's visit: _____

Medical History Please check Yes or No. If yes, please describe.

Yourself

Family Member(s) please list

Grid of checkboxes for medical history including Arthritis, Back Disorder, Cancer, Diabetes, Epilepsy, Stomach Problems, Gout, High Blood Pressure, Heart Condition, Bleeding Disorder, Blood Clots, and Other.

Past surgeries Descriptions Year

Blank lines for past surgeries, descriptions, and years.

Current Medications

Allergies to Medications

Blank lines for current medications and allergies to medications.

Social History Please circle and list how much

Form for social history including Tobacco, Marijuana, Other, Alcohol, and Cocaine.

Signature _____

Date _____