Doctor Initials: _____

Name: _____ Date: _____

Phone Number: _____

Do you have any **allergies** to medications? (circle one) Yes No

_____
_____
_____
_____

Please list any/all **prescribed medications** you are currently taking and the dosage per day in mg.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Do you use tobacco? (circle one) Yes No

What type? _____

If cigarettes, how many packs/day? _____

Height _____ ' _____ Weight: _____lbs

Blood Pressure: _____/_____