

NAME: _____ DATE: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

- (1) _____ (2) _____
- (3) _____ (4) _____
- (5) _____ (6) _____
- (7) _____ (8) _____

LIST ALL SURGERIES THAT YOU HAVE HAD AND DATES:

- (1) _____ (2) _____
- (3) _____ (4) _____
- (5) _____ (6) _____
- (7) _____ (8) _____

ARE YOU TAKING DIET PILLS NOW? YES OR NO IF YES HOW LONG? _____

DO YOU TAKE A BLOOD THINNER? YES OR NO IF YES INFORM DR. STEPHAN

DO YOU SMOKE? YES OR NO DO YOU DRINK? YES OR NO HOW MUCH? _____

ARE YOU PREGNANT? YES OR NO DO YOU HAVE HIV OR HEP-C? CIRCLE

DO YOU HAVE HISTORY OF DRUG ABUSE? YES OR NO

DO YOU HAVE ALLERGIES TO LATEX? YES OR NO

DO YOU HAVE HISTORY OF: (PLEASE SPECIFY)

HIGH BLOOD PRESSURE, HEART DX, DIABETES, CANCER, HIV INFECTION, HEPATITIS, BLOOD TRANSFUSION

- (1) _____ (2) _____
- (3) _____ (4) _____
- (5) _____ (6) _____

LIST ALLERGIES TO MEDICATIONS:

- (1) _____ (2) _____
- (3) _____ (4) _____
- (5) _____ (6) _____

PLEASE INFORM US OF ANY CHANGES AT YOUR FUTURE VISITS