

Patient's First Name

Patient's Last Name

What allergies do you have?

Select Allergies



Allergies not listed

Please add any allergies you don't see in the list above.

What medical conditions do you have?

Select Medical Conditions



Conditions not listed

Please add any problems or conditions that you don't see in the list above.

What medications are you taking?

Select Medications

Type or select medication

Medications not listed

Please add any medications you don't see in the list above.

List any serious illnesses or surgeries

Please add details about any illnesses or surgeries

Has the patient ever been hospitalized?

Yes	No
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Do you smoke?	Yes	No
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Do you drink alcohol?	Yes	No
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High sugar intake?	Yes	No
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Are you Pregnant?	Yes	No
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Are you Nursing?	Yes	No
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Is the patient under the care of a physician?

Yes	No
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Is the patient physically, mentally or emotionally impaired?

Yes	No
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yes	NO
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Patient's current physical health

Please describe the patients current physical health

Signature *

Draw

Sign here

Date: July 23, 2026 at 2:36 PM

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