Name: _____ **Date of Birth:** _____

MEDICATION ALLERGIES _____

_____

_____

_____

ALLERGIC TO LATEX _____ YES_____ NO

MEDICATION	REASON FOR MEDICATION
HERBAL/WEIGHT LOSS PRODUCTS	

PATIENT TO COMPLETE THIS SECTION ***Please circle if applies to you***

General	Weight change, Fatigue, Weakness, Fever, Chills
Skin	Rashes, Lumps, Mole changes, Jaundice Bra size _____
Head	Headaches, Injuries
Eyes	Vision changes, Double vision, Glaucoma, Cataracts
Nose/Sinuses	Runny nose, Nose Bleeds, Hayfever, Allergies
Mouth/Throat	Hoarseness, Sore throat, Dentures
Neck	Lumps, Swollen glands, Goiter, Pain, Injury
Respiratory	Wheezing, Shortness of breath, Cough
Cardiovascular	Heart trouble, High blood pressure, Murmurs, Chest pain, Rapid heart beat
Gastrointestinal	Heart burn, Bloody stools
Urinary	Frequency, Stones, Infections
Neurological	Weakness, Numbness, Seizures, Stroke ***MD reviewed w/pt:*** _____
Psychiatric	Anxiety, Depression
Blood	Anemia/low blood count, Easy bleeding or bruising, Blood clots, HIV, Hepatitis B or C