MEDICAL INFORMATION

Primary Care Physician: _____Phone: _____
Address: _____
Medical Problems:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies to medications: _____

History of (check all that apply):

☐ Heart problems _____ ☐ Breathing Problems _____
☐ High Blood Pressure _____ ☐ Liver Disease _____
☐ Stroke _____ ☐ Kidney Problems _____
☐ Other Neurological Problems _____ ☐ Diabetes _____
☐ Head Trauma _____ ☐ Anemia _____

Tobacco Smoking Status: ❑ daily smoker ❑ occasional smoker
❑ former smoker; quit on _____ ❑ never smoked

Are you pregnant or think you might be? ❑ Yes ❑ No

Current Height: _____ Weight: _____

List ALL current medications/doses: _____
_____
_____
_____
_____
_____
_____
_____
_____

Local Pharmacy:
Name: _____ Town: _____ State: ____ Phone: _____

Mail-Away Pharmacy:
Name: _____ Town: _____ State: ____ Phone: _____