PLEASE ANSWER THE FOLLOWING QUESTIONS

Address ____

Date ______________________ Phone Number ______________

Name ____

Birth Date ____________________ Age ______ Occupation ____________

1. What are the reasons/symptoms for this visit?

   and how long have you had these signs?

2. Have you ever had any serious illnesses, injuries, operations?

   ☐NONE ☐YES____________________ When?________________

   ____________________ ________________

   ____________________ ________________

3. Are you currently taking any medications? Please give the name and the dosage.

4. Are you allergic to any medications or something?

   ☐NONE ☐YES ______________________________

5. Habits

	Amount per day	How many times per week?
Alcohol	___________________	_________________________
Smoking	___________________	

Bowel Habits ☐ Regular ☐Constipated ☐Loose

6. For Women:

Menstrual cycle ☐Regular ☐Irregular

Date of last period ___________________

Is there a possibility you are currently pregnant?

☐YES ☐NO

7. Would you like to mention something else?

Thank you for your cooperation.