

Do you have any medical condition that warrants maintenance medications or physician follow-up?

Explain: _____

Have you ever been hospitalized for any illnesses or operations?

Explain _____

List any allergies you have:

List medications you take:

Are vaccines up to date: Yes _____ **No** _____ **Unsure** _____

Date of last menstrual period: _____

Other pertinent comments:

Current Weight: _____

Name: _____

Patient Signature: _____