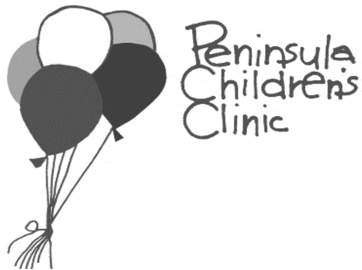

Patient History

PLEASE PRINT   This information becomes part of the confidential medical record

Patient Name ____________________ Date of Birth ____________

Ongoing Medical Problems

❑ No Ongoing Medical Problems

❑ Asthma
❑ ADHD
❑ Diabetes
❑ Seizures

Current Medications

(include supplements and over the counter drugs) ❑ **Not taking Medications**

Name of Medication	Dosage	How often?	What is it for?

Pharmacy

❑ **No current pharmacy**

Name:

Past Surgeries

❑ **No Past Surgeries**

Allergies

❑ **No known allergies**

Agent	**Reaction**