NEW PATIENT INTAKE FORM

NAME: _____ DATE: _____

DATE OF BIRTH: _____ CELL:_____

EMAIL: _____

EMERGENCY CONTACT: _____

MEDICAL HISTORY:

Do you have any problems with bleeding or clotting? YES _____ NO _____

Do you have any allergies? YES _____ NO _____

If yes, please list all food and drug allergies:

_____

MEDICATIONS: *(OTC and prescription)*

_____

_____

Do you take Aspirin, Motrin, Ibuprofen, or anti-inflammatory medication more than once per week?

If yes, please explain: _____

Do you smoke? YES _____ NO _____ N/A _____

If yes, how many times per day/for how many years: _____

Are you currently pregnant? YES _____ NO _____ N/A _____

Are you currently trying to become pregnant? YES _____ NO _____ N/A _____

Are you breastfeeding? YES _____ NO _____ N/A _____

PAST MEDICAL / SURGICAL HISTORY :

Please list if any:

_____

_____

_____ _____

Printed Patient Name **Date** **Signature of Patient**