Name: _____ Date: _____

Email Address: _____ Phone Number: _____

Mailing Address: _____

Date of Birth: _____ Height: _____ Weight: _____ Drug & Food Allergies: _____

Emergency Contact (Name & Phone Number): _____

Primary Physician's Name & Phone Number: _____

Therapist's Name & Phone Number: _____

Current Medications (Name & Dose): _____

_____

_____

Medications taken in the previous year: _____

Past Surgeries & Year: _____

_____

Have you ever had problems with anesthesia: _____

Have you ever had any of the following conditions:

Migraines/Headaches: ___ Seizures: ___ Anxiety: ___ PTSD: ___ Bipolar Dx: ___ OCD: ___ Depression: ___

Suicidal: ___ Stroke/TIA: ___ Dementia/Parkinson's: ___ Schizophrenia: ___ High/Low Blood Pressure: ___

Heart Murmur: ___ Chest Pain: ___ Heart Problems: ___ DVT/PE: ___ Bleeding Disorder: ___ Anemia: ___

Asthma/COPD: ___ Sleep Apnea: ___ Heartburn/Acid Reflux: ___ Stomach Ulcer: ___ Cirrhosis/Hepatitis: ___

Liver Problems: ___ Diabetes: ___ Thyroid Disease: ___ Bladder Problems/Cystitis: ___ Kidney Problems: ___

DO YOU: Use Illicit Drugs ___ Smoke Cigarettes ___ Drink Alcohol ___ Experience motion sickness ___

_____

_____

_____ _____

Signature **Date**